Licensed Clinical Social Worker Psychotherapy "R" Privilege
Form 4Q-SWPR
Review of Qualifications to Supervise Psychotherapy

The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Applicant Instructions

Complete Section I and send the entire form along with a copy of Appendix A directly to the licensed professional who supervised your work experience outside of New York State. Ask the supervisor to complete Section II and send the entire form directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if submitted by the applicant.** Experience completed in New York State must be under a LCSW with the "R" privilege, psychologist, or psychiatrist.

Section I - Applicant Information

1. Social Security Number ☐☐☐☐☐☐☐☐☐
   (Leave this blank if you do not have a U.S. Social Security Number)

2. New York State Licensed Master Social Worker License Number ☐☐☐☐☐☐

3. Print Your Name Exactly As It Appears On Your Application for LCSW Psychotherapy "R" Privilege (Form 1SWPR)

   Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

   First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

   Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. Name of Supervisor your are sending this form to _____

Section II - To be completed by the Supervisor

Note: Do not complete this form if you were licensed in New York State as a licensed clinical social worker, psychologist, or physician during the time you supervised the applicant.

Instructions to Supervisor: Complete this section and return all pages of this form to the Office of the Professions at the address at the end of the form.

1. Supervisor

   Supervisor name _____

   I am a (check all that apply)

   ☐ Licensed Clinical Social Worker _____ (License Number) _____ (Jurisdiction) License date ___ (mo.) ___ (day) ___ (yr.)

   ☐ Licensed Psychologist _____ (License Number) _____ (Jurisdiction) License date ___ (mo.) ___ (day) ___ (yr.)

   ☐ Licensed Psychiatrist _____ (License Number) _____ (Jurisdiction) License date ___ (mo.) ___ (day) ___ (yr.)

   ☐ Other _____ (Describe) _____ (License Number) _____ (Jurisdiction) License date ___ (mo.) ___ (day) ___ (yr.)

   Check type of degree ☐ Ph.D./DSW ☐ Ed.D. ☐ Psy.D. ☐ M.S.W. ☐ M.D.

   Title of Degree _____

   Date of receipt of degree ___ (mo.) ___ (day) ___ (yr.)

   Name of institution where you received this degree _____

Section II - To be completed by the Supervisor (continued)

2. Additional Qualifying Criteria (Complete all that apply for your profession)

Licensed Psychologist

a. ABPP Diplomate in ☐ Clinical ☐ Counseling ☐ School

Year received _____

b. Doctorate in clinical or counseling or school psychology? ☐ Yes ☐ No

If "yes," was it from a program which was New York State registered or APA approved? ☐ Yes ☐ No

c. Did you complete a formal internship which included psychotherapy training? ☐ Yes ☐ No

If "yes," name of program _____ Date completed ____ mo. ____ day ____ yr.

Was the internship accredited by the APA at the time? ☐ Yes ☐ No

d. If your doctorate was in a field other than clinical or counseling or school psychology, did you take formal respecialization program in clinical or counseling or school psychology? ☐ Yes ☐ No

If "yes," name of program _____ Date completed ____ mo. ____ day ____ yr.

Physicians

Are you ABPN certified in psychiatry? ☐ Yes ☐ No If "yes," ABPN Certificate Number _____

LCSW

A qualified supervisor must have at least three years of full-time, post-LCSW supervised experience in **diagnosis and psychotherapy**, prior to supervising the applicant.

Please note that other direct practice with clients does not qualify under New York State Law. In order to determine if you are qualified to supervise, we must have the following information to evaluate your post-LCSW supervised experience in diagnosis and psychotherapy.

Dates of Post-LCSW Experience	Weekly Client Contact Hours	Hours of Individual Supervision/Month	Hours of Group Supervision/Month	Supervisor Name	Supervisor License Number and Jurisdiction

All Supervisors

Have you completed a prescribed postgraduate program in psychotherapy in an institute **chartered by the New York State Board of Regents** or one in another jurisdiction? ☐ Yes ☐ No

If "yes," name of institute _____

Date completed ____ mo. ____ day ____ yr.

Attach a copy of license and Curriculum Vitae.

Section II - To be Completed by the Supervisor (continued)

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise experience for LCSWs. I understand that the information on this form will be used to determine my eligibility as a supervisor of LCSWs seeking the "R" privilege and that the answers given are truthful and accurate to the best of my ability. Any false or misleading information in, or in connection with this certification may be cause for denial of license and may result in criminal prosecution.

Signature _____ Date _____

Print Name _____

Address _____

_____

Telephone _____ Fax _____

Email _____

If the supervisor is not an employee of the same agency as the applicant, please provide information about the applicant's employer:

Name of Agency/Employer _____
(where supervised experience took place)

Address _____

_____

Telephone _____ Fax _____

Email _____

The patient was notified that the agency authorized a third-party supervisor with access to the patient's records.

Name of Agency Representative _____

Signature _____ Date _____

Print Name _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, New York State Board for Social Work, 89 Washington Avenue, Albany, NY 12234-1000.

Reset Form