Licensed Clinical Social Worker Psychotherapy "R" Privilege Form 6SWPR

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

Plan for Post-LCSW Supervised Experience

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensed Clinical Social Worker Psychotherapy "R" Privilege (Form 1SWPR). Be sure to sign and date item 7. Use the psychotherapy log to document your hours of practice and supervision.
2. Send the entire form along with a copy of Appendix A to your supervisor and ask him/her to complete Section II and forward the entire form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Section I: Applicant Information

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

2 **Birth Date** Month Day Year

3 **Print Name as It Appears on Your Application for Licensure (Form 1)**

Last
First
Middle

5 **Telephone/E-Mail Address**

Daytime phone
Area Code Phone

E-mail Address (please print clearly)

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1
Line 2
Line 3
City
State Zip Code
Country/ Province

6 You must complete 2400 client contact hours of post-LCSW experience in psychotherapy over a period of at least 36 months with a minimum of 400 client hours per year. You must have been supervised by a licensed clinical social worker with the "R" privilege, licensed psychologist or physician who meets the requirements of section 74.5 of the Commissioner's Regulations in an acceptable setting as defined in section 74.5.

Name of proposed clinical supervisor: _____

Name of setting: _____

Setting address: _____

LCSW License Number: Date LCSW License issued: Month Day Year

7 **Attestation**

I declare and affirm that the statements made in the foregoing application, including accompanying statements are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial of qualification and may lead to a filing of charges of professional misconduct.

_____ _____ / _____ / _____
Applicant's Signature mo. day yr.

Section II: Supervisor's Verification of Plan for Experience

Instructions For Completing Section II: Please complete Section II, be sure to sign the affidavit, have your signature notarized by a Notary Public and return the entire form directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if returned by the applicant. By completing Section II, the supervisor is certifying that the person named in Section I will receive supervision that meets the requirements specified in Education Law and the Commissioner's Regulations.

1. Name of applicant: _____
(Item 3 on page 1)

2. Name of supervisor: _____
(Supervisor must complete Form 4Q if not already approved by Department)

Title: _____
(attach copy of supervisor's license)

Setting where the applicant will provide diagnosis and psychotherapy services under your supervision:

Name of facility or private practice: _____

Address: _____

The facility is a (check one and attach copy of authorization to provide services):

☐ Private practice owned by LCSW (the applicant)

☐ Private practice owned by supervisor (LCSW-R, Licensed psychologist or psychiatrist)

☐ Professional entity (PLLC, PLLP, P.C.) owned by supervisor (attached consent from SED)

☐ Sole proprietorship or other entity authorized under law (attach certificate of corporation)

☐ Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Correctional Services, State Office for the Aging, or local social service or mental hygiene district (attach operating certificate)

☐ Not-for-Profit or educational corporation authorized by a waiver issued by the State Education Department. (Attach copy of authorization.)

☐ Enrollment in a psychotherapy program in an institution of higher education, psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)

☐ Elementary, middle, high school or college authorized to provide psychotherapy services to students (attach copy of authorization)

☐ Other entity authorized under law to employ licensed professionals and provide services. (Attach copy of certificate of incorporation)

Supervisor:

Education Law and Commissioner's Regulations define acceptable experience as 2400 client contact hours in psychotherapy. The supervisor is responsible for the assessment, evaluation and treatment of patients seen by the applicant and for delegating to the applicant those activities he/she is competent to perform. Failure to provide appropriate supervision could result in charges of unprofessional conduct against the licensed supervisor. A record of client contact hours and supervision hours will be completed and retained by the supervisor who is responsible for submitting verification of the supervised experience.

I am a (check all that apply):

☐ Licensed Clinical Social Worker License number: _____ License date: _____ / _____ / _____
mo. day yr.

☐ Licensed Psychologist License number: _____ License date: _____ / _____ / _____
mo. day yr.

☐ Licensed Physician License number: _____ License date: _____ / _____ / _____
mo. day yr.

Do you have Board certification in psychiatry? ☐ Yes ☐ No

Section II: Supervisor's Verification of Plan for Experience (continued)

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise experience for LCSW's. I understand that the above information will be used to review the plan for supervised experience of the LCSW seeking the LCSW Psychotherapy "R" Privilege and that the answers given are truthful and accurate to the best of my ability. **This form must be signed and dated in the presence of a Notary Public.**

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print name : _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

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)

Agency Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

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

Name of Agency Representative: _____

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print name: _____

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signed, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Expiration date _____ / _____ / _____
Month Day Year

Notary Stamp

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