

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