Licensed Clinical Social Worker Psychotherapy "R" Privilege Form 4SWPR

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

Assigned No.
(From Form 1SWPR)
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Certification of Experience for Licensed Clinical Social Worker Psychotherapy "R" Privilege

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 7. Use the psychotherapy log to document your hours of practice and supervision. This log must be completed by you and your supervisor. All pages of the log must be submitted along with this form.
2. Send the entire form along with a copy of Appendix A to your supervisor (if your supervisor is unavailable, you must provide the supervisor's qualifications and your experience may be verified by a licensed colleague.) 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

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

5 Telephone/E-Mail Address

Daytime phone

Area Code Phone

E-mail Address (please print clearly)

6 Complete this item to verify that you have completed the required supervision experience necessary for the psychotherapy privilege. You must complete 2,400 client contact hours and 36 months of experience, with no less than 400 client contact hours per year **after the experience that qualified you for licensure as an LCSW**. You must have been supervised by a licensed clinical social worker, licensed psychologist or physician who meets the requirements of section 74.5 of the Commissioner's Regulations.

Name of clinical supervisor: ______________________________

Title of supervisor: ______________________________

Name of Agency/Private Practice: ______________________________

Agency/Private Practice address: ______________________________

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

Months of psychotherapy experience after experience that qualified you for licensure as an LCSW: _______

Psychotherapy client contact hours per month: __________

From: _______ / _______ / _______ to: _______ / _______ / _______ please indicate a date no later than today's
mo. day yr. mo. day yr.

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 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 and the psychotherapy log, the endorser is certifying that the person named in Section I received 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)

Supervisor's Qualifications:

☐ Licensed Clinical Social Worker

Years of Psychotherapy Experience: __________

License number: __________________________

MSW Degree from: ______________________________ Degree date: _______ / _______
mo. yr.

☐ Licensed Psychologist

Degree Date: ________ / _______
mo. yr.

License number: __________________________

State: ___________________________________

☐ Psychiatrist

Psychiatric Residency/Training: ______________________________

Medical degree from: ______________________________ Degree Date: _______ / _______
mo. yr.

Board certified in psychiatry? ☐ Yes ☐ No

License number: __________________________

State: ___________________________________

Read this section before completing the remainder of this form.

Part 74.5 of the Commissioner's Regulations requires that the applicant receive supervision of a duration and frequency acceptable to the department for the purpose of improving skills and the assurance of ongoing review of patient/client treatment. Individual supervision must be provided in-person for at least two hours per month for a total of 24 hours per year. Group supervision must be provided for four hours per month for a total of 48 hours per year.

Psychotherapy client contact hours provided by applicant each month: __________________

Applicant was supervised from _______ / _______ / _______ to _______ / _______ / _______ *(please indicate a date no later than today's)*
mo. day yr. mo. day yr.

Applicant received __________ hour(s) per month of individual supervision

Applicant received __________ hour(s) per month of group supervision

Applicant received __________ hour(s) per month of peer supervision

Applicant received __________ hour(s) per month of group supervision in case seminars

Name of institute where case seminars were completed: ______________________________

Section II: Supervisor's Verification of Experience (Continued)

Attestation of Supervisor or Licensed Colleague

NOTE: If you are a licensed colleague attesting to the supervision provided by a qualified supervisor who is not available, and the experience has been completed, you must provide in section II, item 2 of this form:

- the name and qualifications of the supervisor;
- the client contact hours in psychotherapy provided during the supervised experience;
- the dates of supervision provided to the applicant; and
- the frequency and type of supervision sessions.

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the professional experience of the individual named in Section I of this form and that I have read Appendix A and that the experience meets the requirements for the psychotherapy privilege issued by the New York State Education Department.

Signature: ______________________________ Date: _______ / _______ / _______
mo. day yr.

Print name: ______________________________

Agency: ______________________________

Address: ______________________________

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Phone: ______________________________ Fax: ______________________________

E-mail: ______________________________

Licensed as: ______________________________

Licensed in the State of: ______________________________

License number: ______________________________

Notary

State of ______________________________ County of ______________________________

On the _______________ day of ______________________ in the year _____________ before me, the undersigned, 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 ______________________________

Notary Stamp

Expiration date __________ / __________ / __________
Month Day Year

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

Psychotherapy Log: Use this weekly log to document your hours of practice and supervision for Licensed Clinical Social Worker "R" Psychotherapy privilege. **All** pages of this log must be submitted along with Form 4SWPR. Please photocopy this log as needed.

Applicant name: ___________________________________ Supervisor name: ___________________________________

Week starting date for psychotherapy (mm/dd/yy)	Client Contact Hours/Week*	Applicant Initials	Supervision Type (Individual, Group, Peer, Case)**	Supervision Hours/Week**	Supervisor Initials
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***Contact hour = 45 Minutes of psychotherapy (minimum of 10 hours/week; maximum of 20 hours/week)**

****Supervision = at least 2 hours/month of individual <u>or</u> 4 hours/month of group supervision, peer supervision or case seminars from a Regents chartered psychotherapy program acceptable to the State Education Department.**