

Licensed Clinical Social Worker Form 4 Applicant Experience Record

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

1. Complete and send both pages of this form directly to the Office of the Professions at the address at the end of the form. Be sure to sign and date item 10.
2. For your experience to be considered, you must also complete Section I of Form 4B and forward the entire form and a copy of Appendix A to each supervisor you list in item 9 on this form.

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 Your Name Exactly 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/Email Address

Daytime Phone

Email Address (please print clearly)

Area Code

Phone

6. New York State Licensed Master Social Worker License Number

None

7. Date of award of Graduate Social Work Degree

____ mo. ____ day ____ yr.

8. Give any other names by which you have been known

9. List supervisor(s) who will verify your experience for licensure as an LCSW. The supervisor(s) must be an LCSW, licensed psychologist or psychiatrist for experience in New York State. Attach additional sheets if necessary.

The supervisor(s) listed must have supervised your post-M.S.W. experience in diagnosis, psychotherapy and assessment-based treatment plans.

If a supervisor is deceased, you should list a licensed colleague who will attest to your supervised experience and to the qualifications of the deceased supervisor.

Assigned Number	Name of Supervisor and Address of Experience Setting	Dates of Experience	
		From	To
1			
2			
3			
4			
5			
6			

10. 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

Date

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.