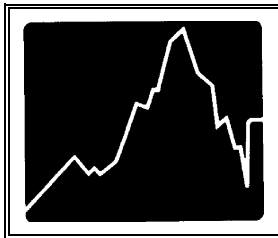


COMMONWEALTH OF VIRGINIA
BOARD OF SOCIAL WORK



Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
(804) 367-4441

Website - <http://www.dhp.virginia.gov/social>

PAPER APPLICATION INSTRUCTIONS FOR
LICENSURE AS A CLINICAL SOCIAL WORKER (LCSW) BY
EXAMINATION

Application:

- Fee:** A \$100.00 application fee must be paid by check or money order made payable to the “Treasurer of Virginia”. This fee is non-refundable and non-transferable.

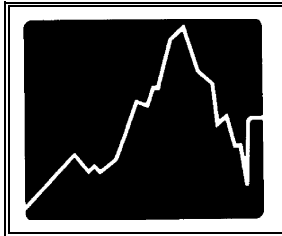
The application can be used for one year from date of receipt.

Supporting Documentation:

Upon completion of the LCSW by Examination application you will be required to submit to the Board office the following items in a single packet:

- Verification of Education:** An official graduate transcript
- If you were previously approved by the Board for supervision, a duplicate transcript is not required.
- Verification of Clinical Supervision:** The Verification of Clinical Supervision form should be completed by your supervisor, verifying 100 hours of face-to-face clinical supervision obtained under a licensed clinical social worker with at least three years of post-licensure clinical social work experience. Original signatures are required.
- Out-of-State Licensure Verification:** If you have ever held a licensure or certification to practice social work, whether current or expired, please send the enclosed verification form to the issuing jurisdiction. This verification is to be completed by the issuing jurisdiction and mailed back to you and included in your application packet. (Some jurisdictions charge a fee for this service. Check with that jurisdiction before sending the form. If the jurisdiction requires submitting this information directly to Virginia’s Board office, please have them indicate your name on the form so that it can be included with your packet for evaluation.) Online verifications will be accepted; however verifications older than six months will not be accepted.
- Licensure Verification of Out-of-State Supervisor:** If your supervisor does not hold a Virginia clinical social worker license, please send the enclosed verification form to the issuing jurisdiction. This verification is to be completed by the issuing jurisdiction and mailed back to you and included in your application packet. (Some jurisdictions charge a fee for this service. Check with that jurisdiction before sending the form. If the jurisdiction requires submitting this information directly to Virginia’s Board office, please have them indicate your name on the form so that it can be included with your packet for evaluation.) Online verifications will be accepted.
- Verification of Education and Field Placement/Practicum Hours:** This form should be completed by the graduate school program official or administration office and mailed directly to you and included with your supportive documentation.
- If you were previously approved by the Board for supervision, a duplicate form is not required.
- Name Change:** Documentation must be provided to show each name change(s) if you name has ever been changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.
- Clinical Scores:** If you have passed the clinical exam in another state within the past five (5) years, please submit verification provided by the Association of Social Work Boards (ASWB). This must be provided by the ASWB by calling (800) 225-6880. Your exam scores will be sent directly from the ASWB to the Virginia Board of Social Work.
- Resume:** A current resume documenting complete employment history. The resume must provide dates of employment and a detailed description of the social work practice associated with the listed employment site.

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**CLINICAL SOCIAL WORKER LICENSURE APPLICATION BY
EXAMINATION**

INSTRUCTIONS	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK		
<u>Applicant must complete all sections.</u>				
I. GENERAL INFORMATION				
Name (Last, First)	(Middle Initial)	(Maiden*) (Suffix)		
Social Security Number or Virginia DMV Control Number**		Date of Birth (MM/DD/YY) / /		
Mailing Address (Street and/or Box Number, City, State, Zip Code)		Home Telephone Number		
Public Address (Street and/or Box Number, City, State, Zip Code)***		Alternate Telephone Number		
E-mail Address				
Name as it appears on your Driver's License				
Are you the spouse of a member of the U. S. military who has been transferred to Virginia and did you leave employment to accompany your spouse to Virginia? <input type="checkbox"/> Yes <input type="checkbox"/> No				
LICENSURE/CERTIFICATION – List in order of attainment all the states in which you now hold or have ever held an occupational license or certificate to practice as a social worker in order of attainment. For each license or certificate indicated below, whether current or lapsed, you must submit a Verification of Licensure form completed by the issuing jurisdiction.				
STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	TYPE OF LICENSE/CERTIFICATE	STATUS
				<input type="checkbox"/> Active <input type="checkbox"/> Expired <input type="checkbox"/> Other
				<input type="checkbox"/> Active <input type="checkbox"/> Expired <input type="checkbox"/> Other
				<input type="checkbox"/> Active <input type="checkbox"/> Expired <input type="checkbox"/> Other

***Name change:** Documentation must be provided to show name change(s) if name has ever been changed from the time you attended school or while you were licensed in other jurisdictions. Photocopies of marriage licenses or court orders are accepted.
****In accordance with § 54.1-116 of the Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles.**
*****Licensure Address is Public Information and Published on the Internet.**

II. EDUCATION:

1. List in chronological order the name and location of each school or other institution, beyond high school, that you have attended. (Use additional paper, if necessary.)

Institution Name	Dates of Attendance (MM/YY) From: To:
Major	Concentration (Choose One) <input type="checkbox"/> Macro/Policy Oriented <input type="checkbox"/> Other: (please specify) <input type="checkbox"/> Clinical/Direct Services _____
Type of Degree Received	Date Degree Conferred
Institution Name	Dates of Attendance (MM/YY) From: To:
Major	Concentration (Choose One) <input type="checkbox"/> Macro/Policy Oriented <input type="checkbox"/> Other: (please specify) <input type="checkbox"/> Clinical/Direct Services _____
Type of Degree Received	Date Degree Conferred
Institution Name	Dates of Attendance (MM/YY) From: To:
Major	Concentration (Choose One) <input type="checkbox"/> Macro/Policy Oriented <input type="checkbox"/> Other: (please specify) <input type="checkbox"/> Clinical/Direct Services _____
Type of Degree Received	Date Degree Conferred

GRADUATE FIELD PRACTICUM INFORMATION:

Graduate Field Practicum Experiences	Dates of Practicum Experiences (MM/YY) From: To:
Primary Duties	
Graduate Field Practicum Experiences	Dates of Practicum Experiences (MM/YY) From: To:
Primary Duties	
Graduate Field Practicum Experiences	Dates of Practicum Experiences (MM/YY) From: To:
Primary Duties	

COMPETENCIES – Regulation 18VAC140-20-150.B., states that licensees may practice only within the competency areas for which they are qualified by education and experience.

Provide the client population you work with or intend to work with and clinical skills you will use in doing so (skills from MSW training). *If requested by the board, this information must be supported by documentation of training or education.*

(Use additional paper, if necessary.)

<u>Client Population</u>	<u>Clinical Skills to be Used</u>
<input type="checkbox"/> Children <input type="checkbox"/> Couples <input type="checkbox"/> Adolescents <input type="checkbox"/> Families <input type="checkbox"/> Adults <input type="checkbox"/> Elderly <input type="checkbox"/> Military <input type="checkbox"/> Other: (Specify) _____	

ANSWER THE FOLLOWING QUESTIONS:	YES	NO
<p>1. Have you ever been denied the privilege of taking an occupational licensure or certification examination? If yes, state what type of occupational examination and where:</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail on a separate sheet of paper.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. Have you ever been convicted of a violation of or pled nolo contendere to any federal, state, or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations and driving under the influence.) If yes, explain in detail on a separate sheet of paper and provide court documents.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>4. In the last twelve (12) months, have you been unable to practice social work by reason of excessive use of alcohol, drugs, chemicals or any other type of material or as a result of any mental or physical condition? If yes, please provide an explanation on a separate sheet of paper.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>5. Have you ever been censored, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper.</p>	<input type="checkbox"/>	<input type="checkbox"/>

III. SUPERVISED CLINICAL SOCIAL WORK EXPERIENCE (Use additional paper, if necessary.)

Indicate below person(s) designated as your supervisor(s) for clinical social work supervised experience.

Supervisor's Name

Business Name and Address of Approved Supervision Work Site Where Applicant Received Hours Towards Licensure

Supervisor's Professional License Type	License Number	State Where Licensed
Supervisor's Name		
Business Name and Address of Approved Supervision Work Site Where Applicant Received Hours Towards Licensure		
Supervisor's Professional License Type	License Number	State Where Licensed
Supervisor's Name		
Business Name and Address of Approved Supervision Work Site Where Applicant Received Hours Towards Licensure		
Supervisor's Professional License Type	License Number	State Where Licensed

The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.

**AFFIDAVIT
(To be completed before a notary public)**

State of _____ County/City of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a clinical social worker in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Signature of Applicant

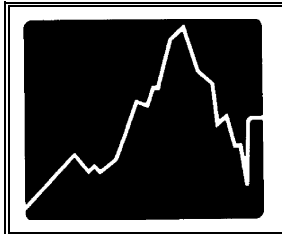
Subscribed to and sworn to before me this _____ day of _____, 20_____.

Signature of Notary Public

My commission expires _____ day of _____, 20_____.

SEAL

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Verification of Clinical Supervision

To verify completion of supervised clinical experience, this form is to be **completed by the supervisor**

I. GENERAL INFORMATION	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK
Name of Applicant (Last, First)	(Middle Initial)	(Suffix)

SUPERVISOR'S INFORMATION:

Name (Last, First)		Business Phone Number
Mailing Address (Street and/or Box Number, City, State, Zip Code)		
Type of License	License Number	State of License
Business Name and Address of Supervision Work Site Where Applicant Received Hours Towards Licensure		
Dates the applicant was under supervision:		
From: (MM/DD/YYYY)	To: (MM/DD/YYYY)	
Number of hours <i>per week</i> of individual, face-to-face clinical supervision: _____ (Minimum 1, Maximum 4)	<u>Total</u> number of hours of individual, face-to-face clinical supervision: _____	
Number of hours <i>per week</i> of group clinical supervision: _____ (Minimum 1, Maximum 4)	<u>Total</u> number of hours of group clinical supervision: _____ (Maximum 50)	

Did applicant receive a minimum of 3,000 hours of post-MSW clinical social work experience?

Yes No (If not, how many? _____)

How many hours *per week* did the applicant spend in face-to-face client contact? _____ (Minimum 15)

EVALUATION OF APPLICANT: To complete the supervision requirements, applicants must demonstrate minimum competency in the areas listed below. Please check your evaluation of the applicant in each area listed below.

ANSWER THE FOLLOWING QUESTIONS:

YES NO

1. Application of an Identified Theory Base

Applicant was able to demonstrate skill in the application of an identified theory base, and was able to comprehend the concepts of major feature of the approach.

PLEASE PROVIDE EXAMPLES OF HOW THE APPLICANT FORMULATED A DIAGNOSES WHILE UNDER SUPERVISION.

WHAT TYPE OF PSYCHOTHERAPY AND COUNSELING TECHNIQUES WERE USED? PLEASE PROVIDE EXAMPLES.

SERVICES PROVIDED TO INDIVIDUALS BY APPLICANT WHILE UNDER SUPERVISION: Amount must equal 100%.

- | | |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Case Management _____ % | <input type="checkbox"/> Community Organization _____ % |
| <input type="checkbox"/> Counseling _____ % | <input type="checkbox"/> Diagnosis of mental and emotional disorders _____ % |
| <input type="checkbox"/> Advocacy _____ % | <input type="checkbox"/> Consultation _____ % |
| <input type="checkbox"/> Policy/Program Development/Administration _____ % | <input type="checkbox"/> Supervision of Others _____ % |
| <input type="checkbox"/> Psychotherapy _____ % | <input type="checkbox"/> Teaching _____ % |
| <input type="checkbox"/> Assessment _____ % | <input type="checkbox"/> Research _____ % |
| <input type="checkbox"/> Information and Referral _____ % | <input type="checkbox"/> Treatment Planning and Evaluation _____ % |
| <input type="checkbox"/> Other (Specify) _____ | |

In your opinion has the applicant demonstrated competency in clinical social work practice sufficient for licensing and the independent practice as a clinical social worker? Please specify how the applicant has demonstrated competency with a brief statement.

DECLARATION OF SUPERVISOR:

I declare that, to the best of my knowledge, the foregoing is true and correct.

Supervisor's Signature

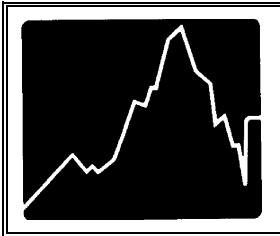
Date

Applicant's Signature

Date

ORIGINAL SIGNATURES REQUIRED

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

To be completed by applicant:

Last Name _____	First Name _____	M.I. _____
Address _____		
City _____	State _____	Zip Code _____
Home Phone Number _____	Work Number _____	
Email Address _____		

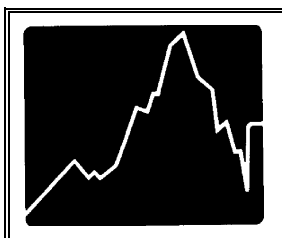
To be completed by state Board of Social Work:

Title of License _____	License Number _____		
Issue Date _____	Expiration Date _____		
<input type="checkbox"/> By Examination	<input type="checkbox"/> By Waiver	<input type="checkbox"/> By Endorsement	<input type="checkbox"/> Reciprocity
Is there any public information relating to this license?			
<input type="checkbox"/> Yes (specify details on a separate sheet)	<input type="checkbox"/> No		

Certification by the authorized Licensure Official of the State of _____
I certify that the information is correct.
Authorized Licensure Official Name and Title _____

State Seal	Title of Board _____
	Telephone Number _____
	Email Address _____
	Date _____

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SUPERVISOR OUT-OF-STATE LICENSURE VERIFICATION

To be completed by applicant:

Last Name _____	First Name _____	M.I. _____
Address _____		
City _____	State _____	Zip Code _____
Home Phone Number _____	Work Number _____	
Email Address _____		

Supervisor's information to be verified:

Last Name _____	First Name _____	M.I. _____
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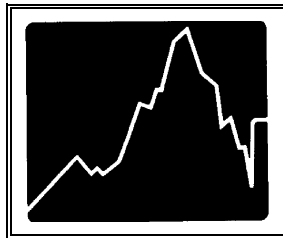
To be completed by state Board of Social Work:

Title of License _____	License Number _____
Issue Date _____	Expiration Date _____
Date received Master's of Social Work (MSW) _____	
Is there any public information relating to this license? <input type="checkbox"/> Yes (specify details on a separate sheet) <input type="checkbox"/> No	

Certification by the authorized Licensure Official of the State of _____
I certify that the information is correct.
Authorized Licensure Official Name and Title _____

State Seal	Title of Board _____
	Telephone Number _____
	Email Address _____
	Date _____

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**VERIFICATION OF EDUCATION AND FIELD PLACEMENT/PRACTICUM
HOURS**

This form must be completed by the graduate school program official or administration office.

TO BE COMPLETED BY THE APPLICANT

Last Name	First Name	M.I.	Maiden or Other
Site Where Practicum Took Place (Business Name, Street, City and Zip Code required)			
Applicant's Student ID Number		Applicant's Social Security Number or VA DMV Number	

TO BE COMPLETED BY THE GRADUATE SCHOOL PROGRAM OFFICIAL OR ADMINISTRATION OFFICE

Part I:

Starting Date of Practicum	End Date of Practicum
Total Number of Practicum Hours or Minimum Hours Required at the Time of Practicum Experience	
<p>I certify, to the best of my knowledge, that the applicant's field placement/practicum supervisor held a licensed clinical social worker (LCSW) license <u>or</u> held a master's or doctorate degree in social work and had a minimum of three years of experience in clinical social work services after earning a graduate degree set forth in Regulation 18VAC140-20-49 of the Virginia Regulations.</p> <p align="center"> <input type="checkbox"/> YES <input type="checkbox"/> NO </p>	

Part II:

Please verify if the following advanced coursework was successfully completed by the applicant as part of a "clinical course of study:" **Check all that apply.**

<input type="checkbox"/> Human Behavior and the Social Environment	<input type="checkbox"/> Social Justice and Policy
<input type="checkbox"/> Psychopathology	<input type="checkbox"/> Diversity Issues
<input type="checkbox"/> Research	<input type="checkbox"/> Clinical Practice with Individuals, Families and Groups

Printed Name of School _____

Printed Name of Program Official _____

Title _____

Signature _____ Date _____