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**

Applicant must complete all sections.

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? ☐ Yes ☐ 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
				☐ Active ☐ Expired ☐ Other
				☐ Active ☐ Expired ☐ Other
				☐ Active ☐ Expired ☐ 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)** ☐ Macro/Policy Oriented ☐ Other: (please specify) ☐ Clinical/Direct Services ____________________
Type of Degree Received	Date Degree Conferred
Institution Name	Dates of Attendance (MM/YY) From: To:
Major	Concentration **(Choose One)** ☐ Macro/Policy Oriented ☐ Other: (please specify) ☐ Clinical/Direct Services ____________________
Type of Degree Received	Date Degree Conferred
Institution Name	Dates of Attendance (MM/YY) From: To:
Major	Concentration **(Choose One)** ☐ Macro/Policy Oriented ☐ Other: (please specify) ☐ 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.)

Client Population	**Clinical Skills to be Used**
☐ **Children** ☐ **Couples** ☐ **Adolescents** ☐ **Families** ☐ **Adults** ☐ **Elderly** ☐ **Military** ☐ **Other: (Specify)** _____	

ANSWER THE FOLLOWING QUESTIONS:	**YES**	**NO**
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:	☐	☐
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.	☐	☐
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.	☐	☐
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.	☐	☐
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.	☐	☐

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 *per week* of **individual, face-to-face** clinical supervision: _____(Minimum 1, Maximum 4)	Total number of hours of **individual, face-to-face** clinical supervision: _____	
Number of hours *per week* of **group** clinical supervision: _____(Minimum 1, Maximum 4)	Total 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.	☐	☐

EVALUATION OF APPLICANT CONTINUED	YES	NO
2. Application of a Differential Diagnosis Applicant was able to demonstrate skill in the application of a differential diagnosis and was able to apply client symptoms and behaviors in formulating a diagnosis.	☐	☐
3. Establishing and Monitoring a Treatment Plan Applicant was able to demonstrate skill in establishing and monitoring a treatment plan, and was able to apply the components of the treatment plan to the diagnostic assessment.	☐	☐
4. Development and Appropriate Use of the Professional Relationship Applicant was able to demonstrate skill in the development and appropriate use of the professional relationship, and was able to apply the necessary skills to develop a professional relationship in the phases of the treatment process.	☐	☐
5. Assessing the Client for Risk of Imminent Danger and Taking Appropriate and Necessary Action to Protect the Safety of the Client, Others, the Public, and the Social Worker When Necessary Applicant was able to demonstrate skill in assessing the client for risk of imminent danger and taking appropriate and necessary action to protect the safety of the client, others, the public, and the social worker when necessary. Applicant was able to apply the criteria for actual or potential risk of a client or professional practice situation and provide the appropriate steps to be taken.	☐	☐
6. Implementing a Professional and Ethical Relationship with Clients Applicant was able to demonstrate skill in implementing a professional and ethical relationship with clients, and was able to apply the appropriate professional and ethical responsibilities in relation to a client situation.	☐	☐
7. Case Management and Record Keeping Applicant maintains appropriate clinical records and client data, and understands the circumstances under which various records can be released.	☐	☐
8. Professional Identity and Ethics Applicant uses supervision and shows continuing development of clinical skills.	☐	☐
Applicant demonstrates knowledge of strengths and limitations of a clinical social worker and the distinctive contributions of other mental health and health professionals.	☐	☐
Applicant makes appropriate referrals to other health providers and resources in the community.	☐	☐
Applicant knows and understands the laws related to life-threatening situations, child abuse, elder abuse, physical abuse, etc.	☐	☐
Applicant understands and has discussed the ethics of confidentiality and other legal and ethical issues.	☐	☐

WHAT POPULATION(S) DID THE APPLICANT WORK WITH WHILE UNDER SUPERVISION?

☐ **Children** ☐ **Couples**

☐ **Adolescents** ☐ **Families**

☐ **Adults** ☐ **Elderly**

☐ **Military** ☐ **Other: (Specify)** _____

SERVICES RENDERED BY THE APPLICANT UNDER YOUR SUPERVISION:

WHAT TYPE OF ASSESSMENTS TECHNIQUES WERE USED WHILE THE APPLICANT WAS UNDER SUPERVISION? PLEASE PROVIDE EXAMPLES.

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%.

☐ **Case Management _____ %**

☐ **Community Organization _____%**

☐ **Counseling _____%**

☐ **Diagnosis of mental and emotional disorders _____%**

☐ **Advocacy _____%**

☐ **Consultation _____%**

☐ **Policy/Program Development/Administration _____%**

☐ **Supervision of Others _____%**

☐ **Psychotherapy _____%**

☐ **Teaching _____%**

☐ **Assessment _____%**

☐ **Research _____%**

☐ **Information and Referral _____%**

☐ **Treatment Planning and Evaluation _____%**

☐ **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.

_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____
_____

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 _____

☐ By Examination ☐ By Waiver ☐ By Endorsement ☐ Reciprocity

Is there any public information relating to this license?

☐ Yes (specify details on a separate sheet) ☐ 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. _____

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? ☐ Yes (specify details on a separate sheet) ☐ 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	

I certify, to the best of my knowledge, that the applicant's field placement/practicum supervisor held a licensed clinical social worker (LCSW) license **or** 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.

☐ YES ☐ NO

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.**

☐ Human Behavior and the Social Environment	☐ Social Justice and Policy
☐ Psychopathology	☐ Diversity Issues
☐ Research	☐ Clinical Practice with Individuals, Families and Groups

Printed Name of School _____

Printed Name of Program Official _____

Title _____

Signature _____ Date _____