Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830
www.bbs.ca.gov

CLINICAL SOCIAL WORKER
IN-STATE EXPERIENCE VERIFICATION

This form is to be completed by the applicant's California supervisor and submitted by the applicant with their *Application for Licensure*. All information on this form is subject to verification.

- Use a separate form for each supervisor and employment setting.
- Ensure that this form is complete and correct prior to signing.
- Supervisor must initial any changes.
- Do not submit Weekly Log forms unless specifically requested

APPLICANT NAME:

Last	First	Middle	Associate Number
			ASW

SUPERVISOR INFORMATION:

Supervisor's Name		Email Address	
Business Phone	**License Type**	**License Number**	**Date First Licensed***

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ☐ N/A ☐ No ☐ Yes: Date Certified: ______________

  Certification Number: ________________

**If licensed in California for less than two years on the first date of experience claimed by the applicant, attach your out-of-state license information*

Were you (the supervisor) employed by the supervisee's employer? ☐ Yes ☐ No

If NO, did you and the supervisee's employer sign a written agreement pertaining to oversight of the supervisee? ☐ Yes ☐ No

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APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer:			Business Phone	
Address: Number and Street		**City**	**State**	**Zip Code**

Applicant: Last	First	Middle

APPLICANT'S EMPLOYER INFORMATION (continued):

1. Was this experience gained in a private practice or professional corporation setting?	☐ Yes ☐ No
2. Was the applicant receiving pay? *If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet been issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status.*	☐ Yes ☐ No

EXPERIENCE INFORMATION:

1. Dates of experience being claimed:	From: ____________________ *mm/dd/yyyy*	To: ____________________ *mm/dd/yyyy*
2. How many supervised weeks of experience are being claimed? __________ Weeks		

3. Total hours in individual or triadic supervision:	
4. Total hours in group supervision:	
5. Average hours worked per week:	
6. Total hours of clinical psychosocial diagnosis, assessment, and treatment, including individual or group psychotherapy or counseling *(Minimum 2,000 overall)*:	**A.**
• Of the above hours, how many were gained performing face-to-face individual or group psychotherapy, provided in the context of clinical social work services? *(Minimum 750 overall)*:	
7. Total hours of client-centered advocacy, consultation, evaluation, research, workshops, seminars, training sessions or conferences and direct supervisor contact* *(Maximum 1,000 overall)*:	**B.**
8. Total hours of experience: **(A + B = C)**	**C.**

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation.

Signature of Supervisor: ____ Date: _______________

ORIGINAL OR ELECTRONIC SIGNATURE REQUIRED