Virginia Department of Health Professions
Board of Social Work

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

**Email**: socialwork@dhp.virginia.gov
**Phone:** (804) 367-4441 **E-Fax:** (804) 977-9915
**Website:** www.dhp.virginia.gov/social

# LICENSURE as a CLINICAL SOCIAL WORKER (LCSW) by EXAMINATION
# Paper Application Checklist Instructions

**IMPORTANT NOTICE:**

Upon completion of the enclosed paper application for licensure as a **Licensed Clinical Social Worker (LCSW)** by **Examination**, you will be required to submit to the Virginia Board of Social Work the below supporting documentation with your application. Prior to **mailing** the enclosed application and below supporting documentation to the Board for consideration, we recommend that you review the Licensure Process Handbook, and the Regulations Governing the Practice of Social Work available on the Board's website at www.dhp.virginia.gov/social to ensure you are applying for the correct application type and have met the requirements for this application type. Pursuant to 18VAC140-20-30(B) of the Regulations Governing the Practice of Social Work, all fees submitted to the Board are **non-refundable**.

We also strongly encourage you to review your application packet to ensure all forms are complete and includes all required forms and documentation. A complete application packet provides the best opportunity to avoid delays in the application review process. You should make every effort to mail all the below information in **one** complete packet to the Board office for consideration.

## REQUIRED DOCUMENTATION

☐ **APPLICATION**: The attached application must be completed and mailed to the Virginia Board of Social Work.

☐ **APPLICATION FEE**: A **$165.00** application fee by check, cashier's check or money order made payable to the **Treasurer of Virginia** must be mailed with your application. Your application will not be reviewed or consider until you have submitted payment. Pursuant to 18VAC140-20-30(B), all fees submitted to the Board are **non-refundable**.

☐ **NPDB SELF-QUERY:** A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be submitted. You may request a self-query at https://www.npdb.hrsa.gov/

☐ **VERIFICATION OF CLINICAL SUPERVISION:** You must provide verification you have complete the supervised experience requirements. The enclosed Verification of Clinical Supervision form should be completed by your supervisor (s) verifying your supervised experience. ***A separate verification of clinical supervision form must be completed for each supervisor.***

☐ **OFFICIAL TRANSCRIPT**: An official transcript (paper or electronic) from an accredited school of social work is required. The transcript must be included in your application packet **or** emailed electronically directly to the Board at socialwork@dhp.virginia.gov via a secured electronic transcript service used by the school (for example: eScript or parchment). **Photocopied transcripts will not be accepted. All official transcripts must include a conferred date.** *If you have been previously approved by the Virginia Board for supervision, a duplicate transcript is not required*.

☐ **VERIFICATION OF PRACTICUM/EDUCATION**: The attached form should be completed by the graduate school program official or administration office and sent directly back to you and included in your application packet. *If you have been previously approved by the Virginia Board for supervision, a duplicate form is not required.*

## ADDITIONAL SUPPORTING DOCUMENTATION (if applicable)

☐ **PROOF OF NAME CHANGE**: Documentation must be provided to show each name change(s) if your name has ever been legally changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Acceptable forms of documentation include a **photocopy** of a marriage license, court order or divorce decree.

☐ **VERIFICATION OF LICENSURE/CERTIFICATION:** If you have ever held a health or mental health license or certification, **whether current or expired**, please send the enclosed verification form to the issuing jurisdiction (s). This verification form should be completed by the issuing jurisdiction (s) and sent 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.)*

**-or-**

You can provide an online verification printed from the licensing jurisdiction's website if the online verification provides **all** of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.

☐ **VERIFICATION OF LICENSURE/CERTIFICATION for OUT-OF-STATE SUPERVISOR:** If your supervisor did not hold a Virginia Clinical Social Work License at the time of your supervised experience, please send the enclosed form from the issuing jurisdiction. This verification form should be completed by the issuing jurisdiction and sent back to you and included in your application packet. Online verification printed from the licensing jurisdiction's website are also accepted if the online verification provides **all** of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.

☐ **EXAM SCORES:** If you have already passed the **CLINICAL** level examination administered by the Association of Social Work Boards (ASWB) in another state, please request the official scores be transferred to Virginia through the ASWB website at https://www.aswb.org/score-transfers/ . Your exam scores will be sent directly from the ASWB to the Virginia Board electronically.

☐ **CRIMINAL CONVICTIONS, PAST ACTIONS or POSSIBLE IMPAIRMENTS**: If you answer "YES" to any of the questions in **Part IV** of the application, please include a detailed explanation **and** supporting documentation. **If you have previously submitted an application to the Virginia Board and there have been no new convictions since your previous submission, please indicate so in your detailed explanation.** *Please refer to Guidance Document 140-2, available on the Board's website, for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments.*

## GENERAL INFORMATION

- Applications are processed in the order received. Please allow adequate processing time for applications. Applications that are complete, fully documented and meet the minimum requirements for the Regulations Governing the Practice of Social Work will be reviewed within **30 days** of receipt of a **complete** application packet.
- Periodically log into the DHP license application portal at: https://www.license.dhp.virginia.gov/apply/Login.aspx to monitor progress of your application and remember "unchecked" items may have been received but are pending review.
- Check your license status by going to: License Lookup (*license information is posted in real time).
- Please notify the Board in writing within 30 days of a name change or address change by completing the **Name/Address Change Form** available on the Board's website at www.dhp.virginia.gov/social.
- An incomplete application for licensure will be retained on file for one (1) year. If not completed within one year of receipt, a new application and fee will be necessary.
- Providing false or misleading information as well as omitting information in response to information requested in the application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing registration or license.
- Pursuant to Virginia Code § 54.1-2400.02 addresses of licensees/supervisees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publically available please complete both sections with same address on the application.
- Pursuant to Virginia Code § 54.1-116 (A), you are required to submit your social security number or your control number issued by the *Virginia* Department of Motor Vehicles*. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FALIED TO DISCLOSE ONE OF THESE NUMBERS.
- Application and required documentation should be **mailed** to:

Department of Health Professions
***Attn: Board of Social Work***
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233

*End of instructions*

Virginia Department of Health Professions
Board of Social Work

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# LICENSURE as a CLINICAL SOCIAL WORKER (LCSW) by EXAMINATION
# Paper Application

| FOR OFFICE USE ONLY (Finance Division) | | | |
|---|---|---|---|
| **Fee Amount Paid** ☐ $ **165.00** | **Applicant ID #** | **Receipt #** | **Date Processed** |

## TO BE COMPLETED BY APPLICANT

**Part I. Applicant Identification & Contact Information**

| Supervisee's Last Name: | First Name: | Middle/Maiden Name: | Suffix: |
|---|---|---|---|
| | | | |

| Social Security Number or Virginia DMV Control Number | Date of Birth: (MM/DD/YYYY) |
|---|---|
| ___ ___ ___ ___ ___ ___ ___ ___ ___ | ___ ___ / ___ ___ / ___ ___ ___ ___ |

**Published Address:** *This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or practice location if you wish.*

| Address: | | |
|---|---|---|
| City: | State: … | Zip Code: ___ ___ ___ ___ ___ |

**Address of Record:** *The address information you provide below is your address of record with the Board. Please be advised that all notices from the Board, to include licenses and other legal documents, will be sent to the address of record provided. If you provided a different public address above, this address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.*

| Address: | | |
|---|---|---|
| City: | State: … | Zip Code: ___ ___ ___ ___ ___ |

| Home Number: | Alternate Number: |
|---|---|
| ( ___ ___ ___ ) ___ ___ ___ - ___ ___ ___ ___ | ( ___ ___ ___ ) ___ ___ ___ - ___ ___ ___ ___ |

Email Address:

**Part II. Education Information:** *List in chronological order each undergraduate school or other institution where course work has been completed.*

| Institution Name: | Type of Degree Received: | Date Graduated: ___ ___ / ___ ___ / ___ ___ ___ ___ |
|---|---|---|
| Institution Name: | Type of Degree Received: | Date Graduated: ___ ___ / ___ ___ / ___ ___ ___ ___ |

**Part III. Licensure History Information:** *List in order of attainment all the states in which you now hold or have ever held a health or mental health license or certification, whether current or expired. If not applicable, enter N/A*

| State | Type of License/Certificate | License/Certificate Number | Issued Date | Current Status |
|---|---|---|---|---|
| … | | | | |
| … | | | | |
| … | | | | |

**Part IV. Licensure Questions:** *Applicant must answer the following questions. Affirmative responses to any questions on this application will require additional information to be submitted. Please refer to Guidance Document 140-2 for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments. Failure to disclose any information related to these questions may be grounds for denial, reprimand, or imposition of terms, suspension or revocation of your license and /or registration.*

| | |
|---|---|
| 1. Have you ever been denied the privilege of taking an occupational licensure, certification or registration examination? ***If Yes, on a separate sheet of paper please provide a full detailed explanation that includes what type of occupational examination, where (jurisdiction), when (dates) and why denied and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No |
| 2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency or practice? ***If Yes, on a separate sheet of paper please provide a full detailed explanation.*** | ☐ Yes ☐ No |
| 3. Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations). Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No |
| 4. Have you ever voluntarily surrendered a license, certification or registration while under investigation? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No |
| 5. Are you the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim? ***If Yes, on a separate sheet of paper please provide a full detailed explanation.*** | ☐ Yes ☐ No |
| **Additional Questions** | |
| 1. **A**. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? ***If Yes, on a separate sheet of paper please provide a full detailed explanation***<br><br>**B**. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| 2. **A**. Within the past five years, have you been disciplined by any entity? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.***<br><br>**B**. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| **3.** Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? *"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Social Worker.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No |
| 4. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? *"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Social Worker.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No |
| 5. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? *"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Social Worker.* ***If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | ☐ Yes ☐ No |
| 6. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? ***If Yes, on a separate sheet of paper please*** | ☐ Yes ☐ No |

| | |
|---|---|
| ***provide a full detailed explanation and attach documents referenced in Guidance Document 140-2.*** | |
| **Part V. Military Service** | |
| 1. Are you a <u>spouse</u> of someone who is on federal active duty orders pursuant to Title 10 of the U. S. Code or of a veteran who has left active-duty service within one year of submission of this application <u>and</u> who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia? | ☐ Yes ☐ No |
| 2. Are you active-duty military? | ☐ Yes ☐ No |

**Part VI. Supervision:** *Indicate below person(s) designated as your supervisor(s) for clinical social work supervised experience. For each out-of-state supervisor indicated, include a completed Supervisor Out-of-State Licensure Verification form.*

*You must have completed a minimum of **3,000 hours** of supervised post-master's degree experience in the delivery of clinical social work services and in ancillary services that support such delivery. A minimum of one hour and a maximum of four hours of face-to-face supervision shall have been provided per 40 hours of work experience for a total of at least **100 hours**. No more than 50 of the 100 hours shall have been obtained in group supervision. Throughout your hours of supervision a minimum of **1,380 hours** of supervised experience shall have been in face-to-face client contact in the delivery of clinical social work services. The remaining hours may have been spent in ancillary services supporting the delivery of clinical social work services.*

*Supervised experience shall have been acquired in no less than two nor more than four years.*

| Supervisor's Name | Begin Date (MM/DD/YYYY) | End Date (MM/DD/YYYY) | Work Site | Supervisor's Title | State |
|---|---|---|---|---|---|
| | | | | | … |
| | | | | | … |
| | | | | | … |
| | | | | | … |
| | | | | | … |
| | | | | | … |
| | | | | | … |
| | | | | | … |

**Part VII. Certification:**. *This application is not valid unless properly certified by your original, electronic, or e-signature.*

I certify by my signature below that I am the person applying for licensure/certificate/registration and meet the qualifications required by Virginia laws and regulations. I certify that I have carefully read the laws and regulations Governing the Practice of Social Work in the Commonwealth of Virginia, which are available at https://www.dhp.virginia.gov/social/.

Further, I certify by my signature below that the information provided on this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information required in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

I agree to the above certification.

| **SIGNATURE:** | **DATE:** |
|---|---|
| | |

**ORIGINAL, ELECTRONIC, OR E-SIGNATURE REQUIRED**

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# VERIFICATION of CLINICAL SUPERVISION

**IMPORTANT NOTICE:**
The applicant should complete the top portion of this form **only**, then provide this form to the supervisor who supervised the applicant's post-master's degree experience. The completed form should be returned to the applicant for inclusion in their application packet that must be sent to the Virginia Board of Social Work. **If supervision took place under more than one Board-approved supervisor, a separate form is required for each supervisor.**

**TO BE COMPLETED BY APPLICANT/SUPERVISEE:** Complete the top portion of this form **only**.

| Last Name: | First Name: | Middle/Maiden Name: | Suffix: |
|---|---|---|---|
| Email Address: | Phone Number: ( ___ ___ ___ ) ___ ___ ___ - ___ ___ ___ ___ | | |

**TO BE COMPLETED BY SUPERVISOR:**

**Part I: Supervisor's Information**

| Last Name: | First Name: | Middle/Maiden Name: | Suffix: |
|---|---|---|---|
| Email Address: | Supervisor's Phone Number: ( ___ ___ ___ ) ___ ___ ___ - ___ ___ ___ ___ | | |

**Part II: Worksite Information** *(location where supervisee obtained post-master's degree experience hours toward licensure)*

| Name of Worksite: | | |
|---|---|---|
| Address of Worksite: | | |
| City: | State: … | Zip Code: _____ _____ _____ _____ _____ |

**Part III: Dates of Supervision**

| Start Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ | End Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ | Total Months: |
|---|---|---|

**Part IV: Hours & Competencies** *(Answers to the below questions should be provided based on the supervision obtained **only** under the instructions of the supervisor completing this form. If the response is "NO" to any of the below questions, please provide an explanation on a separate sheet of paper and provide it with this form to the applicant.)*

| | | | | | |
|---|---|---|---|---|---|
| a. | Did the applicant receive a minimum of one (1) hour and a maximum of four (4) hours of face-to-face supervision per 40 hours of work experience for a total of at least **100** hours with no more than 50 of the 100 hours obtained in group supervision while under your supervision? ***(Do not include hours obtained under another supervisor)*** | ☐ **YES** *Exact # of Hours Obtained* | | ☐ **NO** *If not, how many hours* | |
| | | Individual | Group | Individual | Group |
| b. | Did the applicant complete a minimum of **3,000** hours of supervised post-master's degree experience in the delivery of "clinical social work services" and in ancillary services that support such delivery while under your supervision? ***(Do not include hours obtained under another supervisor)*** | ☐ **YES** *Exact # of Hours Obtained* _____ | | ☐ **NO** *If not, how many hours* _____ | |
| c. | Did the applicant obtain throughout their hours of supervision a minimum of **1,380** hours of supervised experience in face-to-face client contact in the delivery of "clinical social work services" while under your direct supervision? ***(Do not include hours obtained under another supervisor)*** | ☐ **YES** *Exact # of Hours Obtained* _____ | | ☐ **NO** *If not, how many hours* _____ | |
| d. | Did the applicant demonstrate minimum competencies of **identified theory base** while under your supervision? | ☐ **YES** | | ☐ **NO** | |
| e. | Did the applicant demonstrate minimum competencies of **application of a differential diagnosis** while under your supervision? | ☐ **YES** | | ☐ **NO** | |

| | | |
|---|---|---|
| f. Did the applicant demonstrate minimum competencies of **establishing and monitoring a treatment plan** while under your supervision? | ☐ **YES** | ☐ **NO** |
| g. Did the applicant demonstrate minimum competencies of **development and appropriate use of the professional relationship** while under your supervision? | ☐ **YES** | ☐ **NO** |
| h. Did the applicant demonstrate minimum competencies of **assessing the client for risk of imminent danger** while under your supervision? | ☐ **YES** | ☐ **NO** |
| i. Did the applicant demonstrate minimum competencies of **implementing a professional and ethical relationship with clients** while under your supervision? | ☐ **YES** | ☐ **NO** |
| j. Did the applicant demonstrate minimum competencies of **understanding the requirements of law for reporting any harm or risk of harm to self or others** while under your supervision? | ☐ **YES** | ☐ **NO** |
| k. In your opinion, has the applicant demonstrated competency sufficient for licensing and the independent practice as a clinical social worker? | ☐ **YES** | ☐ **NO** |

## Part V: Declaration of Supervisor

I, _____ (name of supervisor) declare by my signature, to the best of my knowledge the foregoing is true and correct.

_____ _____

Signature of Supervisor Date

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**Website:** www.dhp.virginia.gov/social

# VERIFICATION OF EDUCATION & FIELD PLACEMENT/PRACTICUM HOURS

**IMPORTANT NOTICE:**
Pursuant to 18VAC140-20-49(B) of the Regulations Governing the Practice of Social Work, this form should be used and completed by the graduate school program official or administration office to verify the applicant's clinical course of study and field placement/practicum. The completed form should be returned to the applicant for inclusion in their application packet that must be sent to the Virginia Board of Social Work.

**TO BE COMPLETED BY APPLICANT:** Complete the top portion of this form **only**.

| Last Name: | First Name: | Middle/Maiden Name: | Suffix: |
|---|---|---|---|
| | | | |

| Date of Birth: (MM/DD/YYYY) | Last 4 digits of Social Security Number: |
|---|---|
| ___ ___ / ___ ___ / ___ ___ ___ ___ | XXX-XX- _____ _____ _____ _____ |
| Applicant's Student ID Number: | Email Address: |

**TO BE COMPLETED BY GRADUATE SCHOOL PROGRAM OFFICIAL OR ADMINISTRATIVE OFFICE:** Please provide official verification of information requested below. The completed form containing **original or electronic** signature should be returned to the applicant for inclusion in their application packet being mailed to the Virginia Board of Social Work.

***Part I:***

Did the above applicant complete a minimum of **600 hours** of ***advanced*** clinical practicum that focused on diagnostic, prevention, and treatment services?

☐ Yes ☐ No **(If not, how many hours? _____)**

Did the above applicant's field placement/practicum supervisor hold a licensed clinical social worker (LCSW) license **or** hold a master's or doctorate degree in social work with 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 **(If not, explain on separate page)**

***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 of Program Official_____

Signature of Program Official_____ Date _____

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**Website:** www.dhp.virginia.gov/social

# APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

**IMPORTANT NOTICE:**
This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant a health or mental health license or certification. **The Applicant should complete Part I of this form ONLY.** The State Board should complete Part II of this form. The completed form should be returned to the applicant for inclusion in their application packet to be sent to the Virginia Board of Social Work **or** the State Board can send the form electronically to the Virginia Board at socialwork@dhp.virginia.gov

**TO BE COMPLETED BY APPLICANT:** Complete the top portion **only** and send this form to the jurisdiction (s)/State Board (s) that issued you a health or mental health license or certification **(fee may be required)**.

**Part I. Applicant's Identification & Contact Information**

| Last Name: | First Name: | Middle/Maiden Name: | Suffix: |
|---|---|---|---|
| | | | |

| Last 4 digit of Social Security Number: XXX-XX- ___ ___ ___ ___ | Date of Birth: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ |
|---|---|

Address:

| City: | State: | Zip Code: ___ ___ ___ ___ ___ |
|---|---|---|

Email Address:

**TO BE COMPLETED BY STATE BOARD:** Please provide official verification of applicant's licensure information requested below and email completed form to applicant or **directly** to the Virginia Board of Social. **If emailing this form directly to the Virginia Board, please use the subject line: Applicant Licensure Verification *(ref: Applicant's Name)***

**Part II. Applicant's Licensure Information**

| Title of License: | License Number: |
|---|---|
| Issue Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ | Expiration Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ |

License Obtained by:
☐ Examination ☐ Endorsement ☐ Reciprocity ☐ Grandfathered ☐ other _____

Status of License:
☐ Current ☐ Lapsed ☐ Inactive ☐ other _____

Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? ***If yes, please attach certified copy of order issued by State Board.*** YES ☐ NO ☐

I certify the above information to be true in every respect, according to the record on file with the

_____ *(Title of Board)*

Name of Authorized Licensure Official: _____

Title of Authorized Licensure Official: _____

**STATE SEAL**

Telephone Number: _____

Email Address: _____

Date: _____

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**Website:** www.dhp.virginia.gov/social

# SUPERVISOR'S OUT-OF-STATE LICENSURE VERIFICATION

**IMPORTANT NOTICE:**
This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant's supervisor a license/certification to practice social work. **The Applicant should complete Part I & II of this form ONLY.** The State Board should complete Part III of this form. The completed form should be returned to the applicant for inclusion in their application packet to be sent to the Virginia Board of Social Work **or** the State Board can send the form electronically to the Virginia Board at socialwork@dhp.virginia.gov

**TO BE COMPLETED BY APPLICANT:** Complete **Parts I & II only**, then send this form to the Board of Social Work in the state(s) where your **supervisor** was licensed as a Clinical Social Worker **(fee may be required)**.

**Part I. Applicant's Identification & Contact Information**

| Last Name: | First Name: | Middle/Maiden Name: | Suffix: |
|---|---|---|---|
| | | | |

| Last 4 digit of Social Security Number: XXX-XX- ___ ___ ___ ___ | Date of Birth: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ |
|---|---|

Address:

| City: | State: … | Zip Code: ___ ___ ___ ___ ___ |
|---|---|---|

Email Address:

**Part II. (Supervisor's Information to be verified)**

| Supervisor's Last Name: | First Name: | Middle/Maiden Name: | Suffix: |
|---|---|---|---|
| | | | |

**TO BE COMPLETED BY STATE BOARD OF SOCIAL WORK:** Please provide official verification of applicant's supervisor's licensure information requested below and mail or email completed form to applicant or **directly** to the Virginia Board of Social. **If emailing this form to the Virginia Board, please use the subject line: Supervisor Licensure Verification *(ref: Applicant's Name)***

**Part II. Supervisor's Licensure Information**

| Title of License: | License Number: |
|---|---|
| Issue Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ | Expiration Date: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ |

License Obtained by:
☐ Examination ☐ Endorsement ☐ Reciprocity ☐ Grandfathered ☐ other _____

Status of License:
☐ Current ☐ Lapsed ☐ Inactive ☐ other _____

Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? ***If yes, please attach certified copy of order issued by Board of Social Work*** YES ☐ NO ☐

I certify the above information to be true in every respect, according to the record on file with the

_____ *(Title of Board)*

Name of Authorized Licensure Official: _____

Title of Authorized Licensure Official: _____

**STATE SEAL**

Telephone Number: _____

Email Address: _____

Date: _____