



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 to practice clinical 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 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 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) ____ / ____ / ____ ____ | |
| Email Address: | | | |

Part II. Supervisor's Information to be Verified

| | | |
|------------------------------|----------------------------|---------|
| Supervisor's Last Name: | First Name: | Suffix: |
| Supervisor's License Number: | Supervisor's License Type: | |

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 Work. **If emailing this form to the Virginia Board, please use the subject line: "Supervisor Licensure Verification (ref: Applicant's Name)".**

Part III. Supervisor's Licensure Information

| | | |
|---|--|--|
| Title of License: | License Number: | Issuing Jurisdiction: |
| Issue Date: (MM/DD/YYYY) ____ / ____ / ____ ____ | Expiration Date: (MM/DD/YYYY) ____ / ____ / ____ ____ | |
| License Obtained by: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> Reciprocity <input type="checkbox"/> Grandfathered <input type="checkbox"/> other _____ | | |
| Status of License: <input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> |

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: _____

Telephone Number: _____

Email Address: _____

Date: _____

STATE SEAL