Licensed Clinical Social Worker Form 4B
Certification of Experience for Licensed Clinical Social Worker

The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Applicant Instructions

Assigned Number (from Form 4): _____

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 8. Use the psychotherapy log to document your hours of practice and supervision. This log must be completed by you and your supervisor. All pages of the log must be retained by the supervisor, in the event the State Board requests clarification.
2. Send the entire form along with a copy of Appendix A to your supervisor (if your supervisor is unavailable, you must provide the supervisor's qualifications and your experience may be verified by a licensed colleague) and ask him/her to complete Section II and forward the entire form directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if submitted by the applicant. Note: If the experience being certified on this form was completed outside New York State, you must also have a Form 4Q submitted by this supervisor.**

Section I - Applicant Information

1. Social Security Number ☐☐☐☐☐☐☐☐☐ 2. Birth Date Month ☐☐ Day ☐☐ Year ☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

3. Print Your Name Exactly As It Appears On Your Application for Licensure (Form 1)

Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. Mailing Address (You must notify the Department promptly of any address or name changes)

Line 1 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 3 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ ZIP Code ☐☐☐☐☐ ☐☐☐☐

Country/ Province ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. Telephone/Email Address

Daytime Phone ☐☐☐ ☐☐☐ ☐☐☐☐ (Area Code Phone)

Email Address (please print clearly) _____

6. New York State LMSW license number ☐☐☐☐☐☐ M.S.W. degree date ___ ___ ___ (mo. day yr.)

Date LMSW license issued ___ ___ ___ (mo. day yr.) Date registration ends ___ ___ ___ (mo. day yr.)

7. You must complete 2,000 client contact hours of post-MSW supervised experience in diagnosis, psychotherapy and assessment-based treatment plans over a period of at least 36 months and no more than 6 years. You must be supervised by a licensed clinical social worker, licensed psychologist or physician who meets the requirements of section 74.6 of the Commissioner's Regulations in an acceptable setting as defined in section 74.6.

Name of supervisor _____

Name of setting _____

Setting address _____

8. I declare and affirm that the statements made in the foregoing application, including accompanying statements are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial of licensure and may lead to a filing of charges of professional misconduct.

_____ _____

Applicant's Signature Date

Section II - Supervisor's Certification of Supervised Experience

Instructions for Completing Section II: Read the attached Appendix A and complete all of Section II. Be sure to sign the affidavit and return the entire form directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if returned by the applicant. By completing Section II, you are certifying that the person named in Section I will received supervision that meets the requirements as defined in Education Law and the Commissioner's Regulations. **Note:** If you are a licensed colleague attesting to the supervision provided by a qualified supervisor who is not available, and the experience has been completed, you must provide the name and qualifications of the supervisor in item 2 and complete the rest of the information in Section II.

1. Name of the applicant _____
(see Section I, item 3)

2. Supervisor name _____

I am licensed and currently registered to practice as a (check all that apply)

☐ Licensed Clinical Social Worker _____ (License Number) _____ (Jurisdiction) License date ____ (mo.) ____ (day) ____ (yr.)

☐ Licensed Psychologist _____ (License Number) _____ (Jurisdiction) License date ____ (mo.) ____ (day) ____ (yr.)

☐ Licensed Physician _____ (License Number) _____ (Jurisdiction) License date ____ (mo.) ____ (day) ____ (yr.)

Certified in psychiatry? ☐ Yes ☐ No If "yes", ABPN certificate number _____

3. Please identify the employment setting below and attach the operating certificate, NYSED waiver or certificate of incorporation that authorizes the entity to employ LMSWs and LCSWs.

Agency/Practice Name _____

Type of Setting (check one)

☐ Private practice owned by supervisor (LCSW, Licensed psychologist or psychiatrist)

☐ Professional entity (PLLC, PLLP, P.C.) owned by supervisor (attached consent from SED)

☐ Sole proprietorship or other entity authorized under law (attach certificate of corporation)

☐ Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD),Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Corrections and Community Supervision (DOCCS), State Office for the Aging, or local social service or mental hygiene district (attach operating certificate)

☐ Department of Health (DOH) approved hospital or nursing home (attach copy of operating certificate)

☐ Psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)

☐ Elementary, middle, high school or college authorized to provide psychotherapy services to students (attach copy of authorization)

☐ Not-for-profit or other entity authorized by waiver from the State Education Department to employ licensed professionals and provide services (attach waiver and certificate of incorporation)

☐ Other (describe) _____

4. Was the supervised experience for the above named applicant completed outside of New York State? ☐ Yes ☐ No

If yes, the supervisor must complete and submit Form 4Q for review.

5. Have you completed and retained a record of client contact hours and supervision hours of the applicant while under your supervision?

☐ Yes ☐ No

6. Supervision period: starting ____ (mo.) ____ (day) ____ (yr.) ending ____ (mo.) ____ (day) ____ (yr.)

Total number of client contact hours of psychotherapy provided during the period you supervised the applicant _____

Total number of supervision hours you provided _____

Section II - Supervisor's Certification of Supervised Experience (continued)

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise experience for LCSWs. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and the work experience and ability and that the work experience described is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

Supervisor Signature _____ Date _____

Print Name _____

Address _____

_____

Telephone _____ Fax _____

Email _____

Note: If supervisor was not employed by the agency, please provide a copy of the signed agreement between the employer, supervisor and applicant indicating that third-party supervision was authorized and patients were informed as to the sharing of confidential information.

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Social Work Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Reset Form

Psychotherapy Log

Use this weekly log to document the applicant's hours of practice and supervision for Licensed Clinical Social Work. **All** pages of this log must be retained by the supervisor and submitted upon request of the Department. Please copy this log as needed.

Page ____ of ____

Applicant name _____ Supervisor name _____

Week starting date for psychotherapy (mo./day/yr.)			Client Contact Hours/Week*	Applicant Initials	Supervision Type (Individual or Group)**	Supervision Hours/Week	Supervisor Initials

*Client contact hour = 45 minutes of psychotherapy (shorter sessions may be combined)