Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830 TTY: (800) 326-2297
www.bbs.ca.gov

CLINICAL SOCIAL WORKER EXPERIENCE VERIFICATION

The supervisor must complete this form. Use a separate form for each person verifying hours of supervised experience in a clinical setting for licensure as a clinical social worker and for each employment setting. ***Make certain that the form is complete and correct prior to signing. Any change should be initialed by the supervisor and is subject to verification.*** *Experience verification forms are to be submitted by the applicant with his or her application for examination eligibility.*

APPLICANT NAME: _____

SUPERVISOR: (*Please type or print clearly in ink*)

1. SUPERVISOR'S NAME: Last First Middle			2. Business Telephone
3. SUPERVISOR'S ADDRESS: Number and Street	City	State	Zip Code
4. SUPERVISOR'S LICENSE TYPE*: License Number	State of License	Date Originally Licensed	
*If a Physician, were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision?	Yes ☐ No ☐ N/A ☐	Date Board Certified	
5. NAME OF APPLICANT'S EMPLOYER:			
6. EMPLOYER'S ADDRESS: Number and Street			
City	State	Zip Code	7. Business Telephone:

8. Was experience gained in a setting that lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy? Yes ☐ No ☐

9. Was experience gained in a setting that provided oversight to ensure that the associate's work meets the experience and supervision requirements and is within the scope of practice for the profession? Yes ☐ No ☐

10. Dates of experience being claimed: From _____ (Mo Day Yr) To _____ (Mo Day Yr)

11. Total number of supervised weeks worked: (minimum 104):
    a. Total number of hours in individual supervision: a. _____
    b. Total number of hours in group supervision: b. _____

12. Total number of hours worked per week (maximum hours 40): _____

13. A. Total number of hours in clinical psychosocial diagnosis, assessment, and treatment, including individual or group psychotherapy/counseling: (minimum hours required 2,000) A. _____
    A1. Total number of face-to-face individual or group psychotherapy/counseling: (minimum hours required 750) A1. _____
    B. Total number of hours in client-centered advocacy, consultation, evaluation, and research: (max. hours 1,200) B. _____
    C. Total number of hours of experience: (minimum hours required 3,200) **A + B = C** C. _____

14. Was one hour of face-to-face individual or two hours of face-to-face group supervision given for every week in which more than 10 hours of face-to-face psychotherapy was performed? Yes ☐ No ☐

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Supervisor: _____ Date: _____