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

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

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 Name Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business

(You must notify the Department within 30 days of any address or name changes)

Line 1 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 3 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ ZIP Code ☐☐☐☐☐ ☐☐☐☐

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

5. Telephone/Email Address

Daytime Phone

☐ Home or ☐ Business

☐☐☐ ☐☐☐ ☐☐☐☐

Area Code Phone

Email Address (please print clearly)

☐ Home or ☐ Business

_____

6. New York State DMV ID Number (Driver or Non-Driver ID)

☐☐☐☐☐☐☐☐☐

(Leave this blank if you do not have a New York State DMV ID Number)

7. 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.)

8. 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 clinical supervisor _____

Name of setting _____

Setting address _____

9. 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.

_____ _____

Signature Date

Section II: Supervisor's Certification of Supervised Experience

Instructions to the Registrar: 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.

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.

Are you ABPN 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 Addiction Services and Supports (OASAS), Office of Children & Family Services (OCFS), Department of Corrections and Community Supervision (DOCCS), State Office for the Aging, Department of Health (DOH) or local social service or mental hygiene district (attach 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 6503-a or 6503-b 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. Supervisor 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 _____

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 _____

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.