FORM D

ALABAMA STATE BOARD OF SOCIAL WORKER EXAMINERS
Clinical Supervision Verification for LICSW

I. Supervisee's Information

Name:	License Number:
Business name Street address City, State Telephone Fax	____________________ ____________________ ____________________ ____________________

II. Supervisor's Information (completed by supervisor)

Name:	License Number:
Business name Street address City, State Telephone Fax	____________________ ____________________ ____________________ ____________________

III. Supervision Verification (completed by supervisor)

Note: Supervision hours and months must be in whole numbers.

Dates of supervision:	From	(MM/DD/YYYY)	To	(MM/DD/YYYY)	Total Months	
Total number of supervision hours for time listed above (to be applied to the 96-hour requirement):					Total Hours	
Total hours of supervised professional clinical employment experience worked during this verification period (to be applied to the 3,000-hour requirement):					Total Hours	
Supervisee's specific duties:						
Assessment of the supervisee's social work practice knowledge, skills, and abilities:						
Supervisee's therapeutic strengths:						
Areas identified as needing improvement:						

IV. Practice Location Name

Practice Location Name	Address

V. Supervisor's Recommendation

As supervisor of the applicant's clinical experience, do you have any reservations about the applicant being granted a license as a licensed independent clinical social worker?

Yes: ___ No: ___ (If yes, please include a letter outlining your concerns)

VI. Affidavit of Understanding and Signatures

I hereby certify that I have reviewed the regulations pertaining to supervision for specialty recognition in the state of Alabama. I understand that I must observe and comply with the supervision guidelines set forth in the rules.

Under penalties of perjury, I declare and affirm that the statements made above, including accompanying statements, are true, complete, and correct. I understand that any false or misleading information in, or in connection with the supervision plan may be cause for denial or loss supervision time received and/or loss of licensure.

Supervisee Signature		Date	
Supervisee Name Printed			
Supervisor Signature		Date	
Supervisor Name Printed			

Mail To: Alabama State Board of Social Work Examiners, PO Box 301620, Montgomery, Alabama 36130