



**NONCLINICAL SUPERVISION PLAN  
 For LSW and LGSW**

**(Revised August 1, 2011)**

**▪ GENERAL INFORMATION AND INSTRUCTIONS ▪**

**PLEASE TYPE OR PRINT CLEARLY IN BLACK INK AND KEEP ALL PAGES OF THIS FORM TOGETHER.**

1. Submit a separate Supervision Plan form for each social work position. Please use one form to document supervision from multiple supervisors for the same social work position. **A current Supervision Plan form must be on file with the Board.**
2. Complete the entire form, provide all applicable signatures, and **attach your position description for the employment listed below before submitting the form to the Board office, if not previously submitted.**

**DATA CLASSIFICATION:** Information which you and your supervisor(s) provide on this form is classified as public data. As public data, information will be available to any person upon request.

<input type="checkbox"/> INITIAL PLAN	<input type="checkbox"/> REVISED PLAN ( <i>circle change</i> ):	<input type="checkbox"/> Supervisor	<input type="checkbox"/> Employment	<input type="checkbox"/> Scope of Position	<input type="checkbox"/> Type/Amount of Supervision
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SUPERVISION START DATE:	EMPLOYMENT START DATE:	AVERAGE NUMBER OF HOURS WORKED PER WEEK:
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**▪ SUPERVISEE / LICENSEE INFORMATION ▪**

LICENSE NUMBER:	LICENSE: ( <i>check one box</i> ) <input type="checkbox"/> LSW <input type="checkbox"/> LGSW <u>not</u> engaged in clinical social work practice
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LAST NAME (as it appears on license card):	FIRST NAME:	MIDDLE NAME:
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MAILING ADDRESS: (NEW? circle: YES NO)	DAYTIME PUBLIC TELEPHONE:
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CITY:	COUNTY:	STATE:	ZIP CODE:
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AGENCY/EMPLOYER: (no acronyms)	POSITION TITLE: (no acronyms)
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AGENCY ADDRESS: (NEW? circle: YES NO)	LICENSEE E-MAIL:
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CITY:	COUNTY:	STATE:	ZIP CODE:
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**▪ CERTIFICATION BY LICENSEE ▪**

**By signing and dating below, I attest that:**

1. I have read and understand the supervised practice requirements for licensure and hereby affirm that this plan will be carried out as described. I further understand that a *revised Supervision Plan form* must be submitted within 60 days of changes outlined in the Board's Statute, Chapter 148E.125.
2. Failure to submit the **Supervision Plan form** within 60 days after beginning a social work practice position will result in licensee paying the supervision plan late fee specified in section 148E.180 when the licensee applies for license renewal.
3. I understand that I am required to submit a **Supervision Verification form** at license renewal.
4. I understand that my supervisor must have completed a one-time requirement of 30 hours of training in supervision.

LICENSEE/SUPERVISEE SIGNATURE:	DATE:
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**▪ SUPERVISOR #1 ▪ (Supervisor must complete this section.)**

LAST NAME:		FIRST NAME:		MIDDLE NAME:	
PRESENT EMPLOYER:		SUPERVISOR E-MAIL:		DAYTIME PUBLIC TELEPHONE:	
EMPLOYER ADDRESS:					
CITY:			STATE:		ZIP CODE:
LICENSE NUMBER: (Identify if other than Minnesota)		EFFECTIVE DATE OF LICENSE:		LICENSE HELD:	
HIGHEST DEGREE:	MAJOR:		DATE DEGREE CONFERRED:		COLLEGE OR UNIVERSITY:
TITLE AT TIME OF SUPERVISION:			OTHER BOARD LICENSURE:		

**Average number of hours of supervision provided per month as specified below:** \_\_\_\_\_ **Start date of supervision:** \_\_\_\_\_

<p><b>▪ Mandatory One-on-One Supervision Hours</b> (50% required)</p> <p>▪ In-Person hrs/mo _____ (minimum 25%)</p> <p>▪ Eye-to-Eye electronic media hrs/mo _____</p>	<p><b>▪ Other Types of Supervision Permitted</b> (no more than 50% allowed)</p> <p>▪ One-on-One telephone hrs/mo _____</p> <p>▪ Group hrs/mo _____ (may include in-person, telephone, or eye-to-eye electronic media)</p> <p>▪ Number in group, excluding supervisor(s) _____</p>
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**NOTE:** ▪ Group supervision is limited to 6 supervisees.  
 ▪ The supervision must not be provided by e-mail.  
 ▪ If supervisee began supervision under a Supervision Plan submitted prior to August 1, 2011, any remaining supervised practice hours must comply with the new requirements, as specified in MS148E.

<b>As a supervisor, I affirm that the content of the supervision will include:</b>					
Yes	No		Yes	No	
Yes	No	1. development of professional social work knowledge, skills, and values	Yes	No	3. authorized scope of practice
		2. practice methods	Yes	No	4. ensuring continuing competence
					5. ethical standards of practice

**▪ CERTIFICATION BY SUPERVISOR #1 ▪**

As a supervisor, I have completed a one-time requirement of 30 hours of training in supervision. I understand this information will be available to the public.

	Yes	No
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**By signing and dating below, I attest that:**

- I have read and understand the supervised practice requirements for licensure and hereby affirm that this plan will be carried out as described. I further understand that a *revised Supervision Plan form* must be submitted within 60 days of changes outlined in the Board's Statute, Chapter 148E.125.
- I understand that a **Supervision Verification form** must be submitted at the supervisee's license renewal and when the supervisee applies for another license category.

SUPERVISOR #1 SIGNATURE:	DATE:
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LICENSEE/APPLICANT NAME & LICENSE NUMBER: \_\_\_\_\_

**▪ SUPERVISOR #2▪ (Supervisor must complete this section.)**

LAST NAME:		FIRST NAME:		MIDDLE NAME:
PRESENT EMPLOYER:		SUPERVISOR E-MAIL:		DAYTIME PUBLIC TELEPHONE:
EMPLOYER ADDRESS:				
CITY:		STATE:	ZIP CODE:	
LICENSE NUMBER: (Identify if other than Minnesota)		EFFECTIVE DATE OF LICENSE:		LICENSE HELD:
HIGHEST DEGREE:	MAJOR:		DATE DEGREE CONFERRED:	COLLEGE OR UNIVERSITY:
TITLE AT TIME OF SUPERVISION:			OTHER BOARD LICENSURE:	

**Average number of hours of supervision provided per month as specified below:** \_\_\_\_\_ **Start date of supervision:** \_\_\_\_\_

<p><b>▪ Mandatory One-on-One Supervision Hours</b> (50% required)</p> <p>▪ In-Person hrs/mo _____ (minimum 25%)</p> <p>▪ Eye-to-Eye electronic media hrs/mo _____</p>	<p><b>▪ Other Types of Supervision Permitted</b> (no more than 50% allowed)</p> <p>▪ One-on-One telephone hrs/mo _____</p> <p>▪ Group hrs/mo _____ (may include in-person, telephone, or eye-to-eye electronic media)</p> <p>▪ Number in group, excluding supervisor(s) _____</p>
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**NOTE:** ▪ Group supervision is limited to 6 supervisees.  
 ▪ The supervision must not be provided by e-mail.  
 ▪ If supervisee began supervision under a Supervision Plan submitted prior to August 1, 2011, any remaining supervised practice hours must comply with the new requirements, as specified in MS148E.

		<p><b>As a supervisor, I affirm that the content of the supervision will include:</b></p> <p>1. development of professional social work knowledge, skills, and values</p> <p>2. practice methods</p>	Yes	No	<p>3. authorized scope of practice</p> <p>4. ensuring continuing competence</p> <p>5. ethical standards of practice</p>
Yes	No		Yes	No	
Yes	No		Yes	No	

**▪ CERTIFICATION BY SUPERVISOR #2▪**

As a supervisor, I have completed a one-time requirement of 30 hours of training in supervision. I understand this information will be available to the public. I Yes No

**By signing and dating below, I attest that:**

- I have read and understand the supervised practice requirements for licensure and hereby affirm that this plan will be carried out as described. I further understand that a *revised* **Supervision Plan form** must be submitted within 60 days of changes outlined in the Board's Statute, Chapter 148E.125.
- I understand that a **Supervision Verification form** must be submitted at the supervisee's license renewal and when the supervisee applies for another license category.

<b>SUPERVISOR #2 SIGNATURE:</b>	<b>DATE:</b>
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**LICENSEE/APPLICANT NAME & LICENSE NUMBER:** \_\_\_\_\_