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NONCLINICAL SUPERVISION VERIFICATION

For LSW and LGSW

(Revised August 1, 2011)

▪ INSTRUCTIONS TO COMPLETE THIS FORM ▪
PLEASE TYPE OR PRINT CLEARLY IN BLACK INK AND KEEP ALL PAGES OF THIS FORM TOGETHER. 1. Each of your supervisor(s) must complete and submit a separate form. This form may be duplicated. 2. Attach a job description to this form, which corresponds to the position being documented, if not previously submitted. 3. Complete page 1. Then submit the ***entire form*** to your supervisor for completion of pages 2 and 3. Your supervisor must submit all pages of this form directly to the Board.

▪ LICENSEE/APPLICANT INFORMATION ▪
(Applicant/licensee must complete this section.)

▪CIRCLE THE APPLICATION FORM THAT YOU ARE SUBMITTING WITH THIS SUPERVISION VERIFICATION FORM:

▪ LICENSURE APPLICATION	**▪ LICENSURE RENEWAL**	**▪ NOT SUBMITTED WITH AN APPLICATION or RENEWAL**

▪HAVE YOU PREVIOUSLY SUBMITTED A SUPERVISION PLAN FOR THE SUPERVISED PRACTICE REPORTED ON THIS FORM? *(circle)*	**▪ YES**	**▪ NO**

LICENSE NUMBER:	CURRENT LICENSE HELD: *(circle)* LSW LGSW non-clinical scope

LAST NAME (as it appears on license card)	FIRST NAME:	MIDDLE NAME:

MAILING ADDRESS: (NEW? circle: YES NO)	E-MAIL ADDRESS:

CITY:	COUNTY:	STATE:	ZIP CODE:

DAYTIME PUBLIC TELEPHONE:	FAX:

▪ LICENSEE/APPLICANT POSITION INFORMATION SUBMITTED ▪

AGENCY/EMPLOYER NAME FOR POSITION REPORTED ON THIS FORM (may be different from current employment):
AGENCY ADDRESS:

CITY:	COUNTY:	STATE:	ZIP CODE:

LICENSEE/APPLICANT'S POSITION TITLE:

▪RECORD FULL-TIME & PART-TIME PRACTICE DATES & NUMBER OF PART-TIME HOURS PER WEEK FOR THE POSITION REPORTED ▪

▪ FULL-TIME ▪	FROM: (mo/yr)	TO: (mo/yr)	
▪ PART-TIME ▪	FROM: (mo/yr)	TO: (mo/yr)	NUMBER OF HOURS PER WEEK:

▪ *SUPERVISOR SECTION ▪ INSTRUCTIONS FOR SUPERVISOR* ▪

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

All Supervisors:

1. Complete pages 2 and 3.
2. Review the attached position description, if applicable.
3. Submit all pages of this form directly to the Board office at the address listed on the form.

▪ SUPERVISOR INFORMATION ▪

(Supervisor must complete this section.)

LAST NAME:	FIRST NAME:	MIDDLE NAME:	
MAILING 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:
PRESENT EMPLOYER:	SUPERVISOR EMAIL:		
ADDRESS:	DAYTIME PUBLIC TELEPHONE:		
CITY:	STATE:	ZIP CODE:	
TITLE AT TIME OF SUPERVISION:	OTHER BOARD LICENSURE:		

▪ SUPERVISOR'S REPORT OF SUPERVISION PROVIDED *PRIOR TO AUGUST 1, 2011*▪

Dates of Supervision:	FROM: (mo/yr)	TO: (mo/yr)

For the dates listed above, list average number of hours for each type of supervision provided per month below:

▪ In-person one-on-one supervision: ________ ▪ In-person group supervision: _______ ▪ Electronic supervision: ________

▪ Number in group, excluding supervisor(s): ________

NOTE:
- At least ½ of the supervision must be in-person one-on-one supervision.
- In-person group supervision may not exceed more than ½ of the required hours.
- Electronic supervision may not exceed more than 1/3 of the required hours.
- Group supervision may not exceed 7 members, including licensed social work supervisor.

▪ SUPERVISOR'S REPORT OF SUPERVISION PROVIDED *ON OR AFTER AUGUST 1, 2011*▪

Dates of Supervision:	FROM: (mo/yr)	TO: (mo/yr)

For the dates listed above, list average number of hours for each type of supervision provided per month below:

▪ **Mandatory One-on-One Supervision Hours**
(50% required)

▪In-Person hrs/mo _________ (minimum 25%)

▪Eye-to-Eye electronic media hrs/mo _________

▪ **Other Types of Supervision Permitted**
(no more than 50% allowed)

▪ One-on-One telephone hrs/mo_________

▪ Group hrs/mo_________
(may include in-person, telephone, or eye-to-eye electronic media)

▪ Number in group, excluding supervisor(s) ________

NOTE:
- Group supervision is limited to six supervisees.
- Supervision must not be provided by e-mail.

LICENSEE/APPLICANT NAME & LICENSE NUMBER:____

▪ RECOMMENDATION/CERTIFICATION BY THE SUPERVISOR ▪

(Supervisor must complete this section by circling response.)

Yes	No	As a supervisor, you have completed a one-time requirement of 30 hours of training in supervision, and you understand this information will be available to the public.
Yes	No	If you signed a Supervision Plan for the licensee/applicant, do you affirm that the supervision provided for the position documented within this form was carried out as described previously in the Supervision Plan considered and approved by the Board?
Yes	No	Is the position description which the licensee/applicant has attached (if applicable) to this form an accurate reflection of the licensee/applicant's practice? If not, please attach an explanation.
Yes	No	Do you attest that the supervisee has not engaged in conduct in violation of the Standards of Practice specified in the Board's Statute, Chapter 148E.195 to 148E.240?
Yes	No	Do you attest that the supervisee has practiced competently and ethically in accordance with professional social work knowledge, skills and values? If not, please attach an explanation.
		Do you affirm that the content of the supervision has included:
Yes	No	1. development of professional social work knowledge, skills, and values
Yes	No	2. practice methods
Yes	No	3. authorized scope of practice
Yes	No	4. ensuring continuing competence
Yes	No	5. ethical standards of practice

Affirmation: I hereby affirm that I directly supervised the named licensee/applicant and affirm that the supervisee has met the applicable supervised practice requirements. I also affirm that the information I have provided is true and correct to the best of my knowledge. I understand that this information will be used to evaluate the supervisee's compliance with requirements for licensure as a social worker.

SUPERVISOR NAME: *(please print)*	LICENSE HELD & LICENSE NUMBER:
SUPERVISOR SIGNATURE:	DATE:

Classification of Data: Information which you and your supervisor provide on this form is classified as private data prior to licensure and is accessible only to you, Board members and staff, the Board's legal counsel, and persons whom you designate. When your application is approved, the information provided on this form and all other information related to your supervision verification will be classified as public data. Public data is available to any person upon request. The purpose and intended use of this information is to enable the Board to determine whether the documented supervised practice meets statutory requirements for licensure. You are not legally required to provide this information, but the Board will not be able to take action without this information.

SUPERVISOR: PLEASE RETURN THE ORIGINAL FORM DIRECTLY TO THE BOARD OFFICE ADDRESS LISTED ON THE TOP OF THE FIRST PAGE. PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.

LICENSEE/APPLICANT NAME & LICENSE NUMBER: ____

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