



STATE COMMITTEE FOR SOCIAL WORKERS
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City, MO 65102-1335
573-751-0885 Telephone
573-526-3489 Fax
lcsww@pr.mo.gov

Registration of Supervision

Effective April 30, 2010

Dear Sir/Madam,

Thank you for your inquiry into the process of licensure for clinical, baccalaureate, or advanced macro social work in Missouri. Attached you will find the following documents.

- 1. Registration of Supervision Application**
- 2. Contract for Supervision Form**

Registration of Supervision applications are not considered complete until ALL of the following information has been received in the committee office:

- 1. Completed Registration of Supervision Application**
- 2. Completed Contract for Supervision Form**
- 3. \$25.00 Registration Fee**
- 4. Employment verification letter sent on employer's letterhead**
- 5. You must hold a current license as an LMSW (for clinical or advanced macro supervision) or an LBSW (for baccalaureate independent practice supervision)**
- 6. Copy of supervisor's 16-hour supervision training course certificate of completion.**

According to 20 CSR 2263-2.032, supervised social work experience shall be registered for approval by the committee **prior** to the beginning of supervision. This will ensure that the supervision is acceptable to the committee prior to applying for licensure.

The committee remind you to read the rules and statutes regarding supervision. Should you have any questions, please contact the committee office at 573.751.0885 or lcsww@pr.mo.gov



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
REGISTRATION OF SUPERVISION

MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
 STATE COMMITTEE FOR SOCIAL WORKERS

INSTRUCTIONS

- All sections must be completed. If additional information is needed for any questions, please attach a separate sheet.
- Completed applications should be mailed to the following central office address:

DIVISION OF PROFESSIONAL REGISTRATION/
 STATE COMMITTEE FOR SOCIAL WORKERS
 POST OFFICE BOX 1335
 JEFFERSON CITY, MISSOURI 65102-1335
 TELEPHONE: (573) 751-0885
 TDD 800 735-2966
 http://www.pr.mo.gov E-mail: lcsw@pr.mo.gov

- **Applicant is to remain under supervision until license is issued.**

FEES	
Attach registration of supervision fee	\$25
Fees are made payable to the Division of Professional Registration, which are not refundable, in the form of a cashier's check, money order, personal check or bank draft.	

PLEASE CHECK ONE OF THE FOLLOWING

- CLINICAL SOCIAL WORKER BACCALAUREATE SOCIAL WORKER - IP ADVANCED MACRO SOCIAL WORKER

APPLICANT DATA

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)

RESIDENCE STREET ADDRESS (IF PO, PLEASE PROVIDE A STREET ADDRESS ALSO)		CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	DATE OF BIRTH		RESIDENCE TELEPHONE NUMBER	
CURRENT PLACE OF EMPLOYMENT			EMPLOYMENT TELEPHONE NUMBER	
EMPLOYMENT ADDRESS		CITY	STATE	ZIP CODE
E-MAIL		U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, ATTACH COPY OF EVIDENCE OF LEGAL RESIDENT ALIEN STATUS)		

SOCIAL WORK DEGREES:

<input type="checkbox"/> DOCTORATE	SCHOOL NAME	LOCATION	DATE CONFERRED
<input type="checkbox"/> MASTER	SCHOOL NAME	LOCATION	DATE CONFERRED
<input type="checkbox"/> BACCALAUREATE	SCHOOL NAME	LOCATION	DATE CONFERRED

LIST ALL OF THE STATES IN WHICH YOU NOW HOLD OR HAVE EVER HELD A LICENSE/CERTIFICATE TO PRACTICE SOCIAL WORK IN ORDER OF ATTAINMENT. IF CURRENT STATUS IS "OTHER", PLEASE EXPLAIN ON SEPARATE SHEET.

STATE	LICENSE/CERTIFICATE NUMBER AND TITLE CONFERRED BY LICENSE OR CERTIFICATE	ISSUE DATE	CURRENT STATUS
			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER
			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER

ANSWER THE FOLLOWING QUESTIONS (Yes answers must be explained in sworn, notarized affidavit.)	YES	NO
a) Have you ever applied for a license as a social worker and been denied?	<input type="checkbox"/>	<input type="checkbox"/>
b) Has your license or social work privileges ever been revoked, restricted, or have you ever been the subject of disciplinary action by any licensing agency, institution or any other entity?	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you ever entered a plea of guilty or nolo contendere or been convicted of a felony, misdemeanor or received a suspended imposition of sentence?	<input type="checkbox"/>	<input type="checkbox"/>
d) Are you presently being investigated or is there any disciplinary action pending against you?	<input type="checkbox"/>	<input type="checkbox"/>
e) Are you now or ever have been addicted to or used in excess, any drug or chemical substance including alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
f) Are you now being treated or have you ever been treated through a drug or alcohol rehabilitation program?	<input type="checkbox"/>	<input type="checkbox"/>
g) Have you ever been named as a party in a civil suit?	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you ever been disciplined for unethical behavior or unprofessional conduct?	<input type="checkbox"/>	<input type="checkbox"/>
i) Have you ever voluntarily surrendered a professional license?	<input type="checkbox"/>	<input type="checkbox"/>

AGENCY NAME

ADDRESS

DESCRIBE THE SOCIAL WORK DUTIES TO BE PERFORMED BY THE APPLICANT.

APPLICANT'S TITLE DURING SUPERVISORY PERIOD

DATE OF APPLICANT'S EMPLOYMENT	ATTACH VERIFICATION OF EMPLOYMENT (E.G. LETTER FROM EMPLOYER ON OFFICIAL LETTERHEAD)	TOTAL HRS. PER WEEK APPLICANT WILL BE WORKING
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NAME (LAST, FIRST, MIDDLE, MAIDEN)	IS SUPERVISOR A RELATIVE OF THE APPLICANT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, RELATIONSHIP ▶
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ADDRESS (STREET, CITY, STATE, ZIP)	DAYTIME TELEPHONE NUMBER
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PLEASE CHECK ALL THAT APPLY TO SUPERVISOR:

Missouri - License Number _____ ;

Licensed social worker in another state supervising in that state, with an equivalent license - State _____ License Number _____ ; Issue Date _____ ;

ATTACH VERIFICATION OF THE ABOVE CREDENTIAL(S).

NATURE OF SUPERVISION

The Committee recommends that a disclosure statement be presented to each client regarding supervisory status and name of supervisor.

PROPOSED PERIOD OF SUPERVISION (MO/DAY/YR)

NUMBER OF HOURS PER WEEK OF FACE-TO-FACE INDIVIDUAL SUPERVISION.

FROM: TO:

DESCRIBE THE NATURE OF THE SUPERVISION. WILL THE SUPERVISOR REVIEW TAPES, APPLICANT'S NOTES, USE GROUP SESSIONS WITH OTHER PROFESSIONALS, SEMINARS, ETC.? SPECIFICALLY HOW WILL THE SUPERVISOR MAINTAIN RESPONSIBILITY FOR THIS APPLICANT? (ATTACH ADDITIONAL SHEET IF NECESSARY)

ADDITIONAL COMMENTS

STATEMENT OF APPLICANT

I must practice pursuant to this application only under the supervision of an acceptable supervisor, as approved by the State Committee for Social Workers, until I have completed all of the training requirements and have been licensed. I further understand that the minimum acceptable supervised experience shall be 3,000 hours obtained within 24 to 48 consecutive calendar months. If, for any reason, the arrangements for my supervision should change, I will notify the Division of Professional Registration/State Committee for Social Workers immediately. I understand that any supervision obtained without such notification will not be acceptable toward the required number of hours for supervision.

I hereby affirm under penalties of perjury that I am the applicant named in this registration and that all statements and enclosures herein are true and accurate to the best of my knowledge, information and belief.

DATE

SIGNATURE OF APPLICANT

**STATEMENT OF SUPERVISOR**

I have reviewed this proposal for supervised social work experience and accept the responsibility of supervising this applicant during his/her supervised experience. This work will be performed pursuant to my oversight and guidance. If I am unable to complete this supervision arrangement I immediately will advise the Division of Professional Registration/State Committee for Social Workers.

I hereby affirm under penalties of perjury that I am the supervisor named in this registration and that all the statements and enclosures herein are true and accurate to the best of my knowledge, information and belief.

DATE

SIGNATURE OF SUPERVISOR





STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
CONTRACT FOR SUPERVISION

MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
 STATE COMMITTEE FOR SOCIAL WORKERS

This contract must be submitted for approval by the Committee, in addition to the Registration of Supervision form. *Supervision will not be effective until the date it is approved by the State Committee for Social Workers*

I. INFORMATION REGARDING SUPERVISEE

TYPE OF LICENSE APPLYING FOR (PLEASE CHECK ONE)
 LCSW LBSW-IP LAMSW

APPLICANT'S NAME (FIRST, MIDDLE, LAST, SUFFIX, MAIDEN)

DATE OF BIRTH	SOCIAL SECURITY NUMBER
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RESIDENCE ADDRESS (STREET, CITY, STATE, ZIP CODE)

RESIDENCE TELEPHONE NUMBER	RESIDENCE E-MAIL ADDRESS
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CURRENT PLACE OF EMPLOYMENT

EMPLOYMENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

EMPLOYER TELEPHONE NUMBER	EMPLOYER E-MAIL ADDRESS
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II. INFORMATION REGARDING LICENSED SUPERVISOR

SUPERVISOR'S NAME (FIRST, MIDDLE, LAST, SUFFIX, MAIDEN)

DATE OF BIRTH	SOCIAL SECURITY NUMBER
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RESIDENCE ADDRESS (STREET, CITY, STATE, ZIP CODE)

RESIDENCE TELEPHONE NUMBER	RESIDENCE E-MAIL ADDRESS
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CURRENT PLACE OF EMPLOYMENT

EMPLOYMENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

EMPLOYER TELEPHONE NUMBER	EMPLOYER E-MAIL ADDRESS
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STATE OF LICENSE (IF NOT MISSOURI, PLEASE ATTACH OFFICIAL VERIFICATION FROM ANOTHER STATE)

LICENSE NUMBER	LEVEL OF LICENSE
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ORIGINAL ISSUE DATE	EXPIRATION DATE
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HAS THIS LICENSE EVEN BEEN DISCIPLINED?
 YES NO If yes, please submit a full explanation in writing and submit all official documentation pertaining to the disciplinary and/or consent order along with this application.

It is understood that a minimum of four hours per month of face-to-face supervision is required for 24 months within a 48 month period for Social Work Licensure. Fifty percent (50%) may be group supervision. (Group supervision is no less than three and no more than 6 supervisees). You may view the full rules regarding supervision online at www.pr.mo.gov/socialworkers.asp.

METHOD OF SUPERVISION
 Group Individual Combination

PRACTICE SUPERVISED
 Clinical Casework Administrative Community Org Research
 Other (please explain):

IF SUPERVISION IS PROVIDED UNDER CONTRACT, THE COST OF THE SUPERVISION IS
 Free \$_____ hour Other (please explain):

IV. CONFIDENTIALITY (TO BE COMPLETED BY THE LICENSURE SUPERVISOR)

Check this box if the supervisor agrees to adhere to the confidentiality policies of the Supervisee's employing agency.

I understand that 3000 hours of supervised practice must be completed by the supervisee over a minimum of two years and a maximum of four years. The supervision will include a minimum of four hours face-to-face supervision every four weeks between the supervisee and the supervisor noted on this contract. I understand that I must comply with provisions as outlined in this contract and must notify the Committee of any modifications once it has been approved. Failure to do such could result in the loss of supervision hours gained. It is also understood that should my supervisor and/or setting change, a Change of Status form must be completed and approved by the Committee. I further understand that I am to remain under supervision until a license is issued and that each supervisor is required to submit an Attestation form attesting of the supervision provided.

I hereby affirm under penalties of perjury that I am the applicant named in this contract and that all statements and enclosures herein are true and accurate to the best of my knowledge.

SIGNATURE OF SUPERVISEE

DATE

I agree to supervise the supervisee named in this contract and accept full professional responsibility for the work the supervisee will be performing under my supervision. This work will be performed pursuant to my order, oversight and guidance. I understand that 3000 hours of supervised practice must be completed by the supervisee over a minimum of two years and a maximum of four years. Supervision is to include at least four hours of face-to-face supervision every four weeks. I understand that it is recommended that I keep notes and documentation of the supervision that occurs and the issues discussed. As the registered supervisor, I understand that I shall provide annual reports of progress to the committee. These will be due on the anniversary date of the initial approval for the twelfth, twenty-fourth, and thirty-sixth months of supervision. I further understand that I am expected to submit a completed Attestation form to the committee upon completion of the supervision; however, realizing that the supervisee is to remain under supervision until a license is issued. If for any reason I terminate the supervision other than the 3000 hours have been completed, I realize that I must submit the Termination of Supervision form.

I hereby affirm under penalties of perjury that I am the supervisor named in this contract and that all statements and enclosures herein are true and accurate to the best of my knowledge.

SIGNATURE OF SUPERVISOR

DATE

Check this box if you have completed the required 16 hours of supervision training.

Check this box if you have completed three hours of continuing education in supervision in your last renewal period.

You may be asked for copies of these certificates.

ATTENTION SUPERVISOR

If you would like to have your name and contact information added to a listing of qualified supervisors in Missouri, please visit the website at www.pr.mo.gov/socialworkers.asp to complete the request form. This listing will be available online and is public information.