STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
ANNUAL SUPERVISION PROGRESS REPORT

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MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
STATE COMMITTEE FOR SOCIAL WORKERS

INSTRUCTIONS

SUPERVISOR: Complete all items below and return the original (not a photocopy) of this annual supervision progress report as soon as possible to the Missouri Division of Professional Registration, State Committee for Social Workers. **DO NOT RETURN THIS FORM TO THE SUPERVISEE.** It is important that you complete all sections below.

Return completed form to:

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

PLEASE CHECK ONE OF THE FOLLOWING

☐ TWELFTH (12) MONTH (MO-DAY-YEAR TO MO-DAY-YEAR)

☐ TWENTY-FORTH (24) MONTH (MO-DAY-YEAR TO MO-DAY-YEAR)

☐ THIRTY-SIXTH (36) MONTH (MO-DAY-YEAR TO MO-DAY-YEAR)

20 CSR 2263-2.032(12) "The supervisor 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-forth, and thirty-sixth months of supervision. The annual report will provide an overview of the licensee's practice knowledge of the licensure statutes and rules, licensure scope of practice, understanding and adherence to approved standards of professional and ethical conduct, areas of continued growth and development, and accountability of supervision hours thus far in the process."

SUPERVISEE DATA

1. NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX, MAIDEN NAME)

2. ADDRESS (STREET AND BOX NO., IF APPLICABLE, CITY, STATE, ZIP)

SUPERVISOR DATA

3. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN)	4. TELEPHONE NUMBER (DAYTIME)

5. CURRENT OFFICE ADDRESS (STREET AND BOX NO., IF APPLICABLE, CITY, STATE, ZIP CODE)

6. **PLEASE CHECK ALL THAT APPLY TO SUPERVISOR AT THE TIME OF SUPERVISION:**

☐ Missouri - License Number _____ ;

☐ Licensed social worker in another state, supervising in that state, with an equivalent license - State _____ License number _____ ; Original Issue Date _____ ; attach a copy of license.

7. LIST PLACES WHERE THE SUPERVISEE ENGAGES IN PROFESSIONAL EXPERIENCE UNDER YOUR SUPERVISION

AGENCY/FACILITIES	ADDRESS (STREET, CITY, STATE, ZIP)	DATE (MO-DAY-YEAR TO MO-DAY-YEAR)
A.		
B.		
C.		

8. NUMBER OF HOURS **PER WEEK** OF INDIVIDUAL FACE-TO-FACE, ONE-ON-ONE SUPERVISION. ▶	
9. THE TOTAL NUMBER OF HOURS **PER WEEK** THE SUPERVISEE PERFORMS SOCIAL WORK DUTIES WHILE UNDER YOUR SUPERVISION. (THIS SHOULD INCLUDE THE APPLICANT'S TOTAL NUMBER OF HOURS WORKED, IN ADDITION TO THE FACE-TO-FACE, ONE-ON-ONE SUPERVISORY HOURS) ▶	

10. EACH AREA OF PERFORMANCE **MUST** BE RATED BY CHECKING THE NUMBER THAT MOST ACCURATELY DESCRIBES THE SUPERVISEE.

RATING SCALE

1. Not Observed
2. Does Not Meet Expectations
3. Meets Expectations
4. Exceeds Expectations
5. Far Exceeds Expectations

SOCIAL WORK PRACTICE

Please rate and provide additional comments about the supervisee's knowledge, understanding and progress in the following areas:

A. Social work statutes and rules ☐1 ☐2 ☐3 ☐4 ☐5

B. Licensure scope of practice

1. Theoretical framework used in setting ☐1 ☐2 ☐3 ☐4 ☐5

2. Therapeutic delivery skills ☐1 ☐2 ☐3 ☐4 ☐5

3. Assessment skills ☐1 ☐2 ☐3 ☐4 ☐5

4. Diagnostic skills ☐1 ☐2 ☐3 ☐4 ☐5

C. Professional and ethical conduct ☐1 ☐2 ☐3 ☐4 ☐5

Please briefly describe the plan for continued growth and development

Please briefly describe the plan for continued progress over the next reporting period

Do you believe the supervisee is on track to complete the licensure process with a recommendation for full licensure?
☐Yes ☐No (If no, please attach explanation)

11. TESTIMONY OF SUPERVISOR

I hereby affirm under penalties of perjury that the foregoing information which I have supplied is true and accurate to the best of my knowledge, information and belief.

SIGNATURE ▶	DATE

12. TESTIMONY OF SUPERVISEE

I hereby affirm that I have reviewed the information contained in this supervision progress report.

SIGNATURE ▶	DATE