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MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
STATE COMMITTEE FOR SOCIAL WORKERS

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

ATTESTATION OF SUPERVISED SOCIAL WORK EXPERIENCE

INSTRUCTIONS

APPLICANT: Complete items 1-7 and forward to the supervisor whom you wish to have attest to your social work experience.

SUPERVISOR: 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

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

APPLICANT DATA

1. NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX, MAIDEN NAME)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

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

3. DEGREE	4. DATE RECEIVED	5. TELEPHONE NUMBER (DAYTIME)

6. **I hereby authorize the release of information requested below to the Missouri Division of Professional Registration, State Committee for Social Workers.**	7. **APPLICANT SIGNATURE** ▶ **DATE**

DO NOT WRITE BELOW THIS LINE FOR SUPERVISOR'S COMPLETION ONLY

SUPERVISOR: Complete items below and return the original (not a photocopy) of this attestation as soon as possible to the Missouri Division of Professional Registration, State Committee for Social Workers. **DO NOT RETURN THIS FORM TO THE APPLICANT.** It is important that you verify all hours worked under your supervision.

8. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN)	9. TELEPHONE NUMBER (DAYTIME)

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

11. **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.

12. LIST PLACES WHERE THE APPLICANT ENGAGED IN PROFESSIONAL EXPERIENCE UNDER YOUR SUPERVISION

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

13. TITLE APPLICANT HELD DURING SUPERVISION

14. DESCRIBE BRIEFLY THE SETTING(S) WHERE SUPERVISION TOOK PLACE.

15. DESCRIBE THE METHODS OF SUPERVISION USED.

16. EACH AREA OF PERFORMANCE **MUST** BE RATED BY CHECKING THE NUMBER THAT MOST ACCURATELY DESCRIBES THE SUPERVISEE. **EACH SECTION *MUST* INCLUDE COMMENTS (REQUIRED) IN THE AREA PROVIDED.**

RATING SCALE

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

SOCIAL WORK PRACTICE

Demonstrates knowledge of:

A. Human and personality development	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B. Psycho and group dynamics	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
C. Family dynamics	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
D. Psychopathology	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
E. Crisis intervention	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F. Human relations	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G. Interactive effect of biological functioning on the client system	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H. Interactive effect of psychosocial functioning on the client system	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

COMMENTS: **REQUIRED**

Demonstrates skill in:

I. Assessing personality functioning/dysfunctioning	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
J. Assessing client system functioning/dysfunctioning	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
K. Ongoing evaluation of clientele and agency program policies and practices as applicable	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
L. Appropriate selection of intervention, including crisis, strategies and techniques in decision-making	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
M. Appropriate timing and handling of termination process	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
N. Integration of theory with practice skills	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
O. Seeking and using appropriate consultation from other disciplinary sources	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

COMMENTS: **REQUIRED**

Demonstrates:

P. Ability to use supervision to enhance professional growth and functioning	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
1. Willingness to conduct periodic critical review of work and performance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Self awareness and disciplined use of self in all professional relationships	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

COMMENTS: **REQUIRED**

17. NUMBER OF HOURS **PER WEEK** OF INDIVIDUAL FACE-TO-FACE, ONE-ON-ONE SUPERVISION. ▶	
18. THE TOTAL NUMBER OF HOURS **PER WEEK** THE APPLICANT PERFORMED 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) ▶	

19. RECOMMENDATION FOR LICENSURE

☐ WITHOUT RESERVATION

☐ WITH RESERVATION (SPECIFY BELOW)

☐ DO NOT RECOMMEND AT ALL (SPECIFY BELOW)

20. TESTIMONY OF APPLICANT'S 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
▶	

Within fourteen (14) days of the termination of the supervised experience, the supervisor shall complete the committee's Attestation of Supervision Form, summarizing the supervisee's performance and level of compliance with the requirements for supervised social work experience.