



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
SUPERVISION CHANGE OF STATUS

MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
 STATE COMMITTEE FOR SOCIAL WORKERS

INSTRUCTIONS

- All sections must be completed. Additional information may be included by attaching a separate sheet. (573) 751-0885 (Voice Mail)
- Completed form should be mailed to the following central office address: Text Telephone for Hearing Impaired 1-800-735-2966
 State Committee for Social Workers
 Post Office Box 1335
 Jefferson City, Missouri 65102-1335
 http://www.pr.mo.gov E-mail: lcsww@pr.mo.gov

TYPE OF CHANGE (CHECK APPROPRIATE BOX)
 SUPERVISOR(S): ADDITIONAL SUPERVISOR NEW SUPERVISOR **SETTING:** ADDITIONAL NEW

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)		

ANSWER THE FOLLOWING QUESTIONS (Yes answers must be explained in sworn affidavit and accompanied by documents as required in the rules.)

	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b) Has your license or social work privileges ever been revoked, restricted, or have you ever been the subject of disciplinary action by any licensing agency, institution or any other entity?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"/>

SUPERVISED PRACTICE SETTING

INSTITUTION NAME

INSTITUTION ADDRESS

IS INSTITUTION A PRIVATE PRACTICE?
 YES NO (The professional setting shall not include private practice in which the supervisee operates, manages, or has an ownership interest in the private practice)

SUPERVISOR DATA

NAME (LAST, FIRST, MIDDLE, MAIDEN)	IS SUPERVISOR A RELATIVE OF APPLICANT
ADDRESS (STREET, CITY, STATE, ZIP CODE)	DAYTIME TELEPHONE NUMBER

Dates of employment. If not employed by institution, clearly indicate the nature of affiliation with the institution. (Attach letter of employment verification or photocopy of pertinent contract).

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 _____ ; Original Issue Date _____ ;

IDENTIFY INDIVIDUAL(S) WHO HAVE AN OWNERSHIP INTEREST IN THE PRIVATE PRACTICE.

LIST THE INDIVIDUAL(S) ULTIMATELY RESPONSIBLE FOR THE PRIVATE PRACTICE.

NATURE OF SUPERVISION

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

APPLICANT'S PROPOSED POSITION	DATE OF APPLICANT'S INITIAL EMPLOYMENT (ATTACH VERIFICATION LETTER)
TOTAL NUMBER OF HOURS/WEEK APPLICANT WILL BE WORKING	NUMBER OF HOURS/WEEK OF INDIVIDUAL FACE-TO-FACE SUPERVISION
ANTICIPATED COMPLETION DATE FOR SUPERVISION	PROPOSED PERIOD OF SUPERVISION

DESCRIBE THE SOCIAL WORK DUTIES TO BE PERFORMED BY THE APPLICANT, INCLUDING SPECIFIC TYPES OF CASES, CLIENTS, ASSESSMENT PROCEDURES, INTERVENTION ACTIVITIES AND THERAPEUTIC APPROACHES.

DESCRIBE THE NATURE OF THE SUPERVISION. SPECIFICALLY HOW WILL THE SUPERVISOR MAINTAIN FULL PROFESSIONAL RESPONSIBILITY FOR THIS APPLICANT? (ATTACH ADDITIONAL SHEET IF NECESSARY)

(INSERT SOCIAL WORKER IN TRAINING NAME)	(SETTING)	(DATE OF EMPLOYMENT)
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I hereby affirm that _____ is employed at _____ as of _____

EMPLOYER SIGNATURE ▶	DATE
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STATEMENT OF APPLICANT

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 ▶
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STATEMENT OF SUPERVISOR

I have reviewed this proposal for supervised professional experience and accept full professional responsibility for the work this applicant will be performing under my supervision. This work will be performed pursuant to my order, control, oversight and guidance. If I am unable to complete this supervision arrangement I will advise the 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 ▶
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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.