



STATE COMMITTEE FOR SOCIAL WORKERS
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City, MO 65102-1335
Telephone: (573) 751-0885
Fax: (573) 526-4220
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri
lcsw@pr.mo.gov
<http://www.pr.mo.gov>

Application for Licensure – LCSW/LAMSW

Effective April 30, 2010

Dear Sir/Madam,

Thank you for your interest in obtaining the materials to apply for a licensed clinical or advanced macro social worker in Missouri. Attached you will find the following information:

- 1. Application for Licensure Form (Original signature required)**
- 2. Instructions for completing the required fingerprinting/background check**
- 3. Attestation of Supervised Social Work Experience form(s) (Directly from the supervisor only / original signature)**

Application for Licensure files are not considered complete until ALL the following information has been received in the committee office:

- 1. Completed Application for Licensure form (Original signature required)**
- 2. Fingerprinting/Background check results (valid for one (1) year)**
- 3. Application for Licensure fee**
- 4. Completed Attestation of Supervised Social Work Experience form(s) (Directly from the supervisor only / original signature)**
- 5. Evidence of completion of two (2) hours of suicide prevention training**
- 6. Passing exam score from the ASWB**

You will be notified by the committee office in writing after items 1-5 (above) have been received with instructions on contacting the ASWB to schedule for the appropriate examination.

An applicant for licensure who answers “yes” to any question in the application which relates to possible grounds for denial of licensure under section 337.630, RSMo, shall submit a sworn affidavit setting forth in detail the facts that explain the answer and shall submit copies of appropriate documents related to that answer, if requested by the committee.

The committee reminds you to read the rules & statutes regarding licensure. Should you have any questions, please contact the committee office at 573.751.0885 or lcsw@pr.mo.gov

Revised 7/10/2019



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
APPLICATION FOR LICENSURE - LCSW/LAMSW

MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
 STATE COMMITTEE FOR SOCIAL WORKERS

INSTRUCTIONS

1. Applicant must complete all sections, including reference page.
2. If additional information is needed for any questions, please attach a separate sheet.
3. Complete applications should be mailed to the following central office address:

DIVISION OF PROFESSIONAL REGISTRATION/
 STATE COMMITTEE FOR SOCIAL WORKERS
 P.O. 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

FEES	
Attach application fee.	
Oct. 1 to Jan. 31	\$60
Feb. 1 to May 31	\$45
June 1 to Sept. 30	\$30

PLEASE CHECK ONE OF THE FOLLOWING

- CLINICAL SOCIAL WORKER 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 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"/>

POST DEGREE SUPERVISED SOCIAL WORK EXPERIENCE

Indicate below person(s) designated as your supervisor of post-degree supervised social work experience. Attestation forms must be sent directly to the committee by the supervisor, not the applicant.

SUPERVISOR'S NAME	DATES SUPERVISED APPLICANT		TOTAL HRS/WK	HRS ONE TO ONE SUPV/WK
	FROM	TO		
INSTITUTION OR BUSINESS NAME AND ADDRESS				
CURRENT ADDRESS (IF DIFFERENT FROM ABOVE)				
DESCRIPTION OF APPLICANT'S PROFESSIONAL WORK DURING THE SUPERVISION RELATED TO THE PRACTICE OF SOCIAL WORK				

SUPERVISOR'S NAME	DATES SUPERVISED APPLICANT		TOTAL HRS/WK	HRS ONE TO ONE SUPV/WK
	FROM	TO		
INSTITUTION OR BUSINESS NAME AND ADDRESS				
CURRENT ADDRESS (IF DIFFERENT FROM ABOVE)				
DESCRIPTION OF APPLICANT'S PROFESSIONAL WORK DURING THE SUPERVISION RELATED TO THE PRACTICE OF SOCIAL WORK				

SUPERVISOR'S NAME	DATES SUPERVISED APPLICANT		TOTAL HRS/WK	HRS ONE TO ONE SUPV/WK
	FROM	TO		
INSTITUTION OR BUSINESS NAME AND ADDRESS				
CURRENT ADDRESS (IF DIFFERENT FROM ABOVE)				
DESCRIPTION OF APPLICANT'S PROFESSIONAL WORK DURING THE SUPERVISION RELATED TO THE PRACTICE OF SOCIAL WORK				

ACADEMIC OR PROFESSIONAL REFERENCES

APPLICANT NAME	NUMBER OF YEARS KNOWN
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1. This certifies that I have been personally acquainted with the above named applicant for the period stated; that I believe him/her to be of good and professional character, and in every respect worthy of confidence. I hereby recommend him/her to the Division of Professional Registration/State Committee for Social Workers as entirely worthy to be licensed.

SIGNATURE OF REFERENCE	DEGREE	DATE
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REFERENCE NAME (PLEASE PRINT)	PROFESSION OR OCCUPATION
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TITLE	TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP)

APPLICANT NAME	NUMBER OF YEARS KNOWN
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2. This certifies that I have been personally acquainted with the above named applicant for the period stated; that I believe him/her to be of good and professional character, and in every respect worthy of confidence. I hereby recommend him/her to the Division of Professional Registration/State Committee for Social Workers as entirely worthy to be licensed.

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TITLE	TELEPHONE NUMBER
-------	------------------

ADDRESS (STREET, CITY, STATE, ZIP)

APPLICANT NAME	NUMBER OF YEARS KNOWN
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3. This certifies that I have been personally acquainted with the above named applicant for the period stated; that I believe him/her to be of good and professional character, and in every respect worthy of confidence. I hereby recommend him/her to the Division of Professional Registration/State Committee for Social Workers as entirely worthy to be licensed.

SIGNATURE OF REFERENCE	DEGREE	DATE
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REFERENCE NAME (PLEASE PRINT)	PROFESSION OR OCCUPATION
-------------------------------	--------------------------

TITLE	TELEPHONE NUMBER
-------	------------------

ADDRESS (STREET, CITY, STATE, ZIP)

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EXAMINATION REQUESTED CLINICAL ADVANCED GENERALIST**EXAM RESULTS:** Applicant is responsible for having the Association of Social Work Boards submit verification of a passing score as determined by the Committee.**VI. AFFIDAVIT**

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a license to practice as a clinical or advanced macro social worker in the State of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit for consideration the above proofs as required by the Missouri law governing the practice of clinical or advanced macro social work and subject to the rules and regulations of the Division of Professional Registration/State Committee for Social Workers. The Division may require further evidence that it deems reasonable and proper from the sources above.

Enclosed is the application fee made payable to the Division of Professional Registration, **which is not refundable**, in the form of a **money order, personal check, cashier's check or bank draft**.

MUST BE SIGNED IN PRESENCE OF NOTARY PUBLIC	APPLICANT SIGNATURE	
		
	STATE OF	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF 19	
NOTARY PUBLIC EMBOSSEER OR BLACK INK RUBBER STAMP SEAL	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	
		USE RUBBER STAMP IN CLEAR AREA BELOW.



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
**SUICIDE ASSESSMENT, TREATMENT, REFERRAL
AND MANAGEMENT**

MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
STATE COMMITTEE FOR SOCIAL WORKERS

I hereby attest that on _____ I completed a minimum of 2 hours of training the areas of suicide,
(DATE)
assessment, treatment, referrals and management.

SIGNATURE

DATE



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
ATTESTATION OF SUPERVISED SOCIAL WORK EXPERIENCE

MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
 STATE COMMITTEE FOR SOCIAL WORKERS

SUPERVISEE			
SUPERVISOR		EMAIL ADDRESS	
SUPERVISION SETTING	FROM (MONTH/DAY/YEAR)	TO (MONTH/DAY/YEAR)	# MONTHS
ADDITIONAL SETTINGS	FROM	TO	# MONTHS
ADDITIONAL SETTINGS	FROM	TO	# MONTHS

AVERAGE HOURS SPENT IN WEEKLY SUPERVISION Individual:	Group:	AVERAGE NUMBER OF HOURS WORKED WEEKLY IN A SOCIAL WORK POSITION DURING THIS TIME PERIOD	
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Evaluate the applicant/supervisee on the following:	Not Observed	Poor	Average	Above Average	Superior
Social Work Practice					
1. Human and personality development					
2. Psycho and group dynamics					
3. Family dynamics					
4. Psychopathology					
5. Crisis intervention					
6. Human relations					
7. Interactive effect of biological functioning on the client system					
8. Interactive effect of psychosocial functioning on the client system					
Social Work Practice					
1. Assessing personality functioning/dysfunction					
2. Assessing client system functioning/dysfunction					
3. Evaluation of clientele and agency program policies and practices					
4. Appropriate selection of intervention, including crisis, strategies and techniques in decision making					
5. Appropriate timing and handling of termination process					
6. Integration of theory and practice skill					
7. Seeking and using appropriate consultation with other disciplinary sources					
8. Ability to use supervision to enhance professional growth					
9. Willingness to conduct periodic critical review of work & performance					
10. Self-awareness & disciplined use of self in professional relationships					

RECOMMENDATION FOR LICENSURE
 Without Reservation With Reservation Do Not Recommend

PLEASE PROVIDE ANY ADDITIONAL INFORMATION REGARDING THE EVALUATION ABOVE THAT YOU CONSIDER RELEVANT.

I certify that the information above is true and correct to the best of my knowledge. I fully understand that all statements made on this form are subject to verification and that any false and misleading answer may be grounds for refusal or subsequent revocation or suspension of my license.

SIGNATURE OF SUPERVISOR	DATE
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The supervisor must mail the **original** of this form to the State Committee for Social Workers, P.O. Box 1335, Jefferson City, MO 65102-1335 **within 14 days from the termination of supervision**. Fax or email will not be accepted.

Criminal Background Checks – Fingerprinting Requirements

The State Committee for Social Workers uses IdentoGo to fingerprint applicants for licensure/registration.

The Social Workers 4 digit code is **5416** (for ALL applicants within or outside Missouri).

➤ **Individuals needing to be fingerprinted for the State of Missouri.**

- Applicants will need to register with the Missouri Automated Criminal History Site (MACHS) at www.machs.mshp.dps.mo.gov OR telephone **1-844-543-9712**.
- The Social Workers 4 digit code is **5416** (for ALL applicants within or outside Missouri).
- Please note your Transaction Control Number (TCN). The TCN will be required at the time of fingerprinting to confirm your MACHS registration data.
- Applicants must have a recent photograph to present to the vendor prior to being fingerprinted.
- Your processing fee is automatically calculated based on the 4-digit registration number that you provide. Fees are either paid at the time of registration or are payable to IndentoGO at the time of fingerprinting. Upon completion of the fingerprint appointment, IndentoGO will transmit your fingerprint background check request to the Missouri State Highway Patrol (MSHP) for processing through the state and FBI. The results of the search will be provided to the authorized agency within 5 to 10 business days.

Please visit <https://www.machs.mshp.dps.mo.gov/MACHSFP/faq.html> regarding Frequently Asked Questions and fees regarding a finger-print based background check the MACHS.