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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

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		

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

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.