IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 20/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

SOCIAL WORK VERIFICATION OF SUPERVISION & EXPERIENCE

SUPPORTING DOCUMENT

VE-SW

APPLICANT: Complete the applicant section of this form, then forward it to your supervisor(s). A separate form is required from each supervisor for each experience.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month / Day / Year)

3. SSN OR ITIN __ __ __ – __ __ – __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE

6. MAIDEN OR GIVEN SURNAME

5. PROFESSION (Check One)

- ☐ **Licensed Social Worker (150)**
- ☐ **Licensed Clinical Social Worker (149)**

COMPLETE BOXES 7, 8, 9, 10 AND 11 TO REFLECT INFORMATION AT TIME OF EMPLOYMENT/EXPERIENCE

7. CLINICAL SUPERVISOR'S NAME & TITLE

8. BUSINESS / INSTITUTION / SITE OF EXPERIENCE HOURS

9. BUSINESS / INSTITUTION / SITE ADDRESS

10. SUPERVISION WAS (Mark only one):

☐ **Internal** **OR** ☐ **Contracted Outside Supervision**

11. TYPE OF EXPERIENCE BEING REPORTED (MARK ONLY ONE- A SEPARATE FORM IS REQUIRED FOR EACH EXPERIENCE).

- ☐ **Bachelor's degree + 3 years experience for LSW** Rules 68 IAC Section 1470.20(b)
- ☐ **3000 Supervised Clinical Hours for LCSW** Rules 68 IAC Section 1470.20(a)
- ☐ **Exam Alternative for LCSW** 225 ILCS 20/8.2

SUPERVISOR: Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT IN A SEALED ENVELOPE.

PART I. - SOCIAL WORK SUPERVISION INFORMATION

A. NAME OF SUPERVISOR COMPLETING THIS FORM

B. QUALIFICATION TO SUPERVISE:

- ☐ Licensed Clinical Social Worker (LCSW)
- ☐ Licensed Social Worker (LSW)
- ☐ Licensed Clinical Professional Counselor (LCPC)
- ☐ Licensed Marriage and Family Therapist (LMFT)
- ☐ Licensed Clinical Psychologist
- ☐ Licensed Psychiatrist
- ☐ Licensed Advanced Practice Psychiatric Nurse
- ☐ Other (specify): _____

C. LICENSE STATE | D. LICENSE NUMBER | E. DATE AWARDED

F. BUSINESS TELEPHONE NUMBER

Area Code (__ __ __) __ __ __ – __ __ __ __

G. EMAIL ADDRESS (OF SUPERVISOR COMPLETING THIS FORM)

H. The individual listed above and I met for an average of at least 4 hours each month for the purpose of conducting supervision. ☐ YES ☐ NO

If NO, how often was supervision? _____ hours / month.

I. My supervision was coordinated with another clinical supervisor. ☐ YES ☐ NO

If YES, the other supervisor's name was:

_____

(A separate VE-SW form is required from each supervisor.)

J. APPLICANT'S JOB TITLE AT TIME EXPERIENCE

K. NAME OF SUPERVISOR'S BUSINESS / INSTITUTION / AGENCY

L. SUPERVISOR'S BUSINESS/ INSTITUTION/ AGENCY ADDRESS

PART I. - SOCIAL WORK SUPERVISION INFORMATION (Continued)

M. **Bachelor's + 3 years experience for LSW.** THIS BOX IS ONLY FOR HOURS COMPLETED FOR FIRST TIME ILLINOIS LSW LICENSURE ON THE BASIS OF A BACHELOR'S DEGREE PURSUANT TO RULES 68 IAC SECTION 1470.20(b).

The applicant completed the following supervised **PROFESSIONAL** experience under my supervision. The experience being counted and reported started as listed below and continued at least until the end date listed below.

_____(must be **after** Bachelor's degree was awarded) _____ Total: _____
START DATE (MM/DD/YYYY) END DATE (MM/DD/YYYY) MONTHS and YEARS

The experience was conducted in accordance with Rules 68 IAC Section 1470.20(b). ☐ YES ☐ NO

N. **3000 Supervised Clinical Hours for LCSW (2000 for Doctorate degree applicants).** THIS BOX IS ONLY FOR HOURS COMPLETED FOR FIRST TIME IL LCSW LICENSURE PURSUANT TO RULES 68 IAC SECTION 1470.20(a).

The applicant completed the following supervised **CLINICAL** experience under my supervision. The experience being counted and reported started as listed below and continued at least until the end date listed below.

_____(must be **after** Master's or Doctorate degree was awarded) _____
START DATE (MM/DD/YYYY) END DATE (MM/DD/YYYY)

The experience is ongoing. ☐ YES ☐ NO Total Number Clinical Hours: _____

The experience was conducted in accordance with Rules 68 IAC Section 1470.20(b). ☐ YES ☐ NO

O. **Exam Alternative for LCSW.** THIS BOX IS ONLY FOR HOURS COMPLETED FOR LCSW EXAM ALTERNATIVE PURSUANT TO 225 ILCS 20/8.2.

The applicant completed the following supervised **PROFESSIONAL** experience under my supervision. The experience being counted and reported started as listed below and continued at least until the end date listed below.

_____(must be **after** clinical experience of 1470.20(a).) _____ Total hours: _____
START DATE (MM/DD/YYYY) END DATE (MM/DD/YYYY) (EXAM ALTERNATIVE HOURS ONLY)

The experience I am verifying was separate from (and in addition to) the 3000 hours (2000 for doctorate degree applicants) completed or counted for supervised clinical experience per Rules 68 IAC Section 1470.20(a).

☐ YES ☐ NO

The experience was conducted in accordance with 225 ILCS 20/8.2. ☐ YES ☐ NO

P. The applicant's performance was satisfactory or better. ☐ YES ☐ NO

The above indicated experience has been documented by myself and has been performed by the applicant pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

_____
Signature

_____ _____
Date Title

NAME (Last, First, MI):

SSN OR ITIN:

Profession: