New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Social Work Examiners
124 Halsey Street, 6th Floor, P.O. Box 45033
Newark, New Jersey 07101
(973) 504-6495
www.njconsumeraffairs.gov/sw

Documentation of Supervised Clinical Experience Form for LCSW Candidates

Instructions: Please complete one form per supervisor and per title (multiple titles or supervisors cannot be combined on one form). Forms that contain missing or inaccurate information will not be accepted. **This form must be completed by both you and your supervisor before you upload it to your eGov portal in addition to your on-line application.**

Section 1 To be Completed by the Supervisee:

Last Name: _____ First Name: _____ M.I.: ____ Maiden: _____

LSW License No.: _____ Initial NJ LSW License issued: ____ / _____ / _____

Do you hold an out-of-state Social Worker license? ☐ Yes ☐ No

Out-of-State License No. (if applicable): _____ ☐ N/A

Your title during the supervisory period: _____
(If you had multiple job titles, you must complete separate clinical supervision forms for each title.)

Section 2 To be Completed by the Supervisor:

Last Name: _____ First Name: _____ M.I.: ____ Maiden: _____

LCSW License No.: _____ Date of Initial NJ LCSW Licensure: ____ / _____ / _____

State(s) of Licensure: _____ 20-Hour Supervisory Certification Date: ____ / _____ / _____

Section 3

REPORT OF HOURS:

Instructions: Please provide the number of supervised hours your supervisee completed in the areas below. Hours must be completed in no less than two and no more than four years. See N.J.A.C. 13:44G-4.1 for more detail. For definitions of the types of work referenced in A, B, and C, please see N.J.A.C. 13:44G-1.2.

A. Face-to-Face Clinical Client Contact: _____ Total Supervised Hours: _____
(minimum of 960 hours required) (add A, B, & C)

B. Psychotherapeutic Counseling: _____ Total Months of Supervised experience: _____
(minimum of 960 hours required) (Minimum of 24 Months)

C. Non-Clinical Hours: _____
(maximum to 1080 hours are allowed)

You must include a date by which the hours listed were accrued.

Supervision Start Date: ____ / _____ / _____ Supervision End Date: ____ / _____ / _____

- Were the months of supervision consecutive? ☐ Yes ☐ No (Do not include significant gaps in the total number of months above.)
- Name of Agency where work was performed: _____

Address of Agency where work was performed:

Street _____ City_____ State _____ Zip_____

- Profit Status: ☐ For-Profit ☐ Non-Profit ☐ Government/Exempt
- Social Work Functions Performed by the Applicant during their time in supervision

☐ Case Management
☐ Information and
☐ Referral Research
☐ Treatment Planning
☐ Assessment
☐ Advocacy
☐ Policy and Program Development, Implementation, and Administration
☐ Psychotherapy
☐ Counseling
☐ Community Organization
☐ Diagnosis of Mental an Emotional Disorders
☐ Other (Specify)

_____

Supervisor's Signature: _____ Date: _____

Section 4 Supervised Postion Information and Asssesment to be Completed by the Supervisor

Applicant's title during the time I supervised them: _____
This must match the title on the official HR job description submitted with this form.

Average hours per week under my face- to- face supervision: _____ (See N. J. A. C. 13: 44G- 8. 1(b)(v))

Average hours per week I spent in group supervision with the applicant: _____ (See N. J. A. C. 13: 44G- 8. 1(b)(v))

Section 5 Checklist of Supervisor Activities

The following is a checklist of activities performed during the course of supervision.

☐ I worked together with the clients and/or observed the applicant's sessions with clients.
☐ I viewed/listened to recordings of the applicant's sessions with clients.
☐ I reacted to case presentations given by the applicant.
☐ I conducted role-playing sessions with the applicant.
☐ I engaged in problem-solving discussions with the applicant regarding individual clients.
☐ I entered into problem-solving discussions concerning the applicant's own problems, in so far as such problems were affecting the applicant's work with clients.
☐ I offered feedback to the applicant regarding specific interventions utilized with a client.
☐ I offered feedback concerning the applicant's personal qualities as they affect work with clients.
☐ I offered feedback to the applicant regarding the supervision experience.

NOTE: As the supervisor, you are required to attach a separate sheet which includes a detailed description of the direct clinical services provided to the clients by the applicant while they were under your supervision.

Section 6 Supervisor's conclusions and recommendations

This applicant is seeking to become a licensed clinical social worker in New Jersey. By this application, the applicant is claiming readiness for unsupervised, independent clinical practice. In assessing the applicant's professional readiness, you are now being asked if the applicant possesses the following abilities and knowledge.

The ability to establish a professional relationship.	☐ Yes	☐ No
The ability to assess a client's needs and to plan appropriate interventions.	☐ Yes	☐ No
The ability to make interventions appropriate to client needs.	☐ Yes	☐ No
The ability to be flexible in choosing and changing interventions as appropriate.	☐ Yes	☐ No
The ability to assess prudently one's own capacities and skills in a professional situation.	☐ Yes	☐ No
The ability to work effectively in a one-to-one relationship.	☐ Yes	☐ No
The ability to work effectively in a group situation.	☐ Yes	☐ No
The ability to work effectively where systems-level interventions are required.	☐ Yes	☐ No
The applicant demonstrates ethical behavior.	☐ Yes	☐ No

(Optional) On a separate sheet of paper, in summary fashion, please give us your assessment of the applicant' s current state of preparedness for independent clinical practice. This is especially important if you are not recommending this applicant for an independent, clinical license at this time. Your recommendation is an important element in the Board' s determination of the applicant' s qualifications.

In light of the above, ☐ I recommend ☐ I do not recommend that the applicant obtain clinical licensure.

Supervisor Signature: _____ Date: _____

Section 7 Supervisor and Supervisee Attestation:

By signing below, we are hereby attesting that:

- The information contained on this form is true and correct to the best of our knowledge;
- The required number of client-contact hours were completed within a 2-4 year period;
- The required number of client-contact hours were compliant with N.J.A.C. 13:44G-4.1(a)
- Supervision of the supervisee occurred for a minimum of one-hour per week, either in an individual or group setting;
- We have read and understand the most recent version of the Laws and Regulations, particularly those related to clinical supervision and LCSW eligibility requirements; and
- The reported supervision obtained during the supervisory period are otherwise compliant with N.J.A.C. 13:44G-8.1

Section 8 Final signatures and attachments:

☐ Supervisee's official job description on agency letterhead, the title of this position should match the title listed on page two of this form (the job description should reflect duties that conform to the definition of "clinical social work services" in N.J.A.C. 13:44G-1.2).

☐ Supervisor's resume or curriculum vitae

☐ Supervisor's copy of supervisory credential (20 continuing education credits of post-graduate course-work from a Board-approved entity related to clinical supervision pursuant to N.J.A.C. 13:44G-8.1(b)(3)(ii)).

☐ If the supervision is being rendered in an agency setting by a supervisor who is not employed by the agency, a letter from the employer on letterhead consenting to outside supervision (See N.J.A.C. 13:44G-8.1(i)).

Supervisor Signature: _____ Date: _____

Supervisee Signature: _____ Date: _____

Section 9 Proposed Plan of Supervision:

Did you previously submit a Proposed Plan of Supervision related to the experience you have documented on this form?
☐ Yes ☐ No

If "No," skip the rest of this section
If "Yes," please provide the following information before submitting this form:

Date of Proposed Plan submission: _____

Applicant's job title, as listed on the Proposed Plan: _____

Name of the Supervisor listed on the Proposed Plan: _____

Did you receive a Board determination regarding your proposed plan? ☐ Yes ☐ No
If "Yes," you must include the Board's letter regarding the plan in your submission of this form.