



**New Jersey Office of the Attorney General**

Division of Consumer Affairs  
State Board of Social Work Examiners  
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**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. 3,000 hours under direct supervision required. 1920 hours must be in face-to-face client contact, and at least half of the 1920 hours must be in psychotherapeutic counseling specifically (minimum 960). The other 1,080 hours can include time spent in supervision or other social work services. See N.J.A.C. 13:44G-1.2, 4.1 and 8.1 for more detail.

A. Face-to-Face Clinical Client Contact: \_\_\_\_\_  
(Clinical assessment and clinical consultation hours, up to 960 accepted toward your 1920 total.)

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)

Total Work Experience Hours: (add A, B, & C) \_\_\_\_\_

Supervision Start Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Supervision End Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**You must include a date by which the hours listed were accrued.**

➤ 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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Case Management                   | <input type="checkbox"/> Assessment   | <input type="checkbox"/> Counseling                                  |
| <input type="checkbox"/> Information and Referral Research | <input type="checkbox"/> Advocacy   | <input type="checkbox"/> Community Organization                      |
| <input type="checkbox"/> Treatment Planning                | <input type="checkbox"/> Policy and Program Development, Implementation, and Administration | <input type="checkbox"/> Diagnosis of Mental and Emotional Disorders |
|  | <input type="checkbox"/> Psychotherapy  | <input type="checkbox"/> Other (Specify)                             |

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 4 Supervised Position Information and Assessment 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.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The ability to assess a client's needs and to plan appropriate interventions.                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The ability to make interventions appropriate to client needs.                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The ability to be flexible in choosing and changing interventions as appropriate.            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The ability to assess prudently one's own capacities and skills in a professional situation. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The ability to work effectively in a one-to-one relationship.                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The ability to work effectively in a group situation.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The ability to work effectively where systems-level interventions are required.              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The applicant demonstrates ethical behavior.   | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 for the title(s) you held during supervision. The Board considers a job description "official" if it bears agency letterhead and is issued from Human Resources as the standard agency job description for your title. Note: we will not accept a letter written for you specifically, it must be the standard job description and 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.