



GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,  
 SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS  
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APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE  
 SOCIAL WORK DIRECTED EXPERIENCE VERIFICATION FORM - FORM B

**INSTRUCTIONS: NO FAXED FORMS ACCEPTED**

- Please print or type.
- **APPLICANT** – Complete Part I and forward this form to the agency or organization in which you completed your directed experience practicing Social Work.
- **AGENCY OR ORGANIZATION** - The Director must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.

PART I – APPLICANT

NAME OF APPLICANT:

First Middle Last Maiden

SOCIAL SECURITY NUMBER: \_\_\_\_\_

This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

PART II – AGENCY OR ORGANIZATION

**INSTRUCTIONS:**

- "Direction" means the on-going administrative oversight of an employer or superior of a practitioner's work (**Unpaid or Volunteer experiences are NOT acceptable in meeting the directed work experience requirement**).

CERTIFICATION

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL PRACTICED COMPENSATED SOCIAL WORK AT:

\_\_\_\_\_  
 Name of Agency or Organization

Address: \_\_\_\_\_  
 Street City State Zip Code

From: \_\_\_\_\_ To: \_\_\_\_\_ For \_\_\_\_\_ Hours Per Week.

\_\_\_\_\_  
 Date Signature of Director or Authorized Person

\_\_\_\_\_  
 Name of Agency or Organization  
 (If different than noted above as the practice location)

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Title/Position

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 Telephone: ( ) City State Zip Code  
 Fax: ( )