



GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
 SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
 237 Coliseum Drive
 Macon, Georgia 31217-3858
 (478) 207-2440 (Telephone)
www.sos.state.ga.us/plb/counselors

**CLINICAL SOCIAL WORKER
 DIRECTED EXPERIENCE - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
 FORM E**

INSTRUCTIONS: NO FAXED FORMS ACCEPTED.

■ Please type or print clearly.

The Directed Experience Supervisor must be:

PRIOR TO JULY 1, 1987 — A licensed Psychologist, Psychiatrist or have earned an MSW from a CSWE-accredited program.

JULY 1, 1987 - JULY 1, 1996 — A licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist, Psychiatrist or a member of the Academy of Certified Social Workers.

AFTER JULY 1, 1996 — A licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist or Psychiatrist and has practiced in their specialty for at least 2000 clock hours over 2 years following licensure. See Board Rule Chapter 135-5-.04(5)(f) -(h).

APPLICANT:

- Make every effort to locate the as many of the supervisors of Directed Experience as necessary to document the required Directed Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Supervisors to document the required time, you may attest to undocumented Directed Experience by taking the Oath below.
- The Board may require additional information upon review.

PART I - APPLICANT

NAME:

SOCIAL SECURITY NUMBER:

I obtained experience: Prior to July 1, 1987 July 1, 1987 - July 1, 1996 After July 1, 1996

PART II - OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: _____

who served as my supervisor while I worked under the direction of: _____

Name of Director

at: _____

Name of Agency or Organization Address City State Zip Code

and that this supervisor has the following credentials:

License Type: Professional Counselor Clinical Social Worker Marriage and Family Therapist
 Psychologist Psychiatrist Member of the Academy of Certified Social Workers

Earned an MSW from a CSWE-accredited program

License #: _____ State: _____ Date Issued: _____ Expir. Date: _____ Years of Practice After Licensed: _____

The supervision of my Social Work Practice was provided during the following 12-month period/s:

YEAR 1 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 2 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 3 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 4 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:

 Date
 Sworn to and subscribed before me this
 _____ day of _____, _____.

 Signature of Applicant

 Notary Public
 My Commission Expires: _____

NOTARY SEAL