APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER

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

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Social Work in the State of Georgia. Visit the Board’s website for information.

**Important**
The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications are void after one year, and you will have to reapply. Please allow at least twenty-five (25) business days for processing of your application, if it is complete. Incomplete applications will take longer to process.

Application Checklist
The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The NON-REFUNDABLE APPLICATION FEE made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (Please see Fee Schedule located on the Board’s website www.sos.ga.gov/plb/counselors).

- **NOTARIZED APPLICATION:** The application must be mailed to the Board’s office at the address listed above along with your FEE. All questions must be answered. Any question answered “yes” may require additional documentation to be submitted such as: official court documents and a written explanation of any criminal convictions and/or charges, or disciplinary sanctions by another state licensing or regulatory board. The Board will review a complete application with all required documentation during its next scheduled meeting. Approval of licensure is at the Board’s discretion.

- **ASWB EXAM SCORES:** If you have not taken the CSW exam thru ASWB, you will receive the exam approval letter with information after Board approval. All applicants are required to pass the Association of Social Workers Board (ASWB) national Clinical Social Work Examination. If you have taken the ASWB-CSW exam, please contact them at 1-888-579-3926 and have them certify your scores to Georgia.

- **DEGREE TRANSCRIPT:** All applicants for licensure must have earned a Master’s degree in Social Work and graduated from an institution accredited by the Council on Social Work Education. An official college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school.

- **GEORGIA DOES NOT OFFER ENDORSEMENT OR RECIPROCITY LICENSURE FOR A SOCIAL WORK LICENSE:** If you have taken the Clinical Social Work exam thru ASWB, you would apply for license by exam waiver and request an official score transfer from ASWB. If you have not taken the Clinical Social Work exam thru ASWB, you would apply for license by exam.

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**OTHER STATE LICENSURE CERTIFICATION/FORM N:** If you are currently, or have ever been licensed in another State(s) or jurisdiction, please have that/those State(s) or jurisdictions officially certify your license directly to the Georgia Board’s office.

**FORM B-DIRECTED EXPERIENCE FROM:** The director/employer must document the on-going administrative oversight of an employee or superior of a practitioner’s work.

**FORM C-SUPERVISION VERIFICATION FORM:** The supervisor must document the direct clinical review for the purpose of training or teaching of a Social Worker’s interaction with a client(s). Documentation of having acquired 120 hours of supervision during the same period of directed experience. **THE GA BOARD WILL ONLY ACCEPT THIS FORM – DO NOT SUBMIT FORMS USED BY OR SUBMITTED TO ANOTHER STATE REGULATORY ENTITY**

**REFERENCES:** Must have two (2) references by teachers or supervisors who are familiar with their experience in Social Work.

**BACKGROUND INFORMATION:** The Board requires applicants to disclose all previous arrests, history of treatment for substance abuse or dependence and discipline by other regulatory boards. If you have ever been arrested, received treatment, or been disciplined by any other regulatory board or agency please provide a certified copy of the official documents showing the final disposition or order relevant to the incident as well as a personal, detailed letter of explanation regarding each incident. Also, you must report any disciplinary action or investigation involving any professional license you may hold or have held, in any state, jurisdiction or territory, and, submit copies of the official court or other official document(s) which indicate the final disposition of any reported incidents as noted above. **You are expected to read each question carefully and completely and to notify the Board of any changes in the background information you report on this application.**

**IMPORTANT:** Applicants: please note when accessing your application status on our website under the Online Services tab’s link, “Check the Status of an Application”, that checklist items that indicate “completed” only means that those documents have been received. This tool is to be used as an option for you to monitor your application for items received as you are going through the licensure process.

Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists have the authority to approve or deny an application for licensure. **Every application file must be submitted to the Board for review.** The Board meets monthly to review applications and conduct other Board business. Once your application file has been reviewed by the Board, you will receive written communication of the Board’s decision within five to ten business days following the Board meeting.

**PLEASE DO NOT SUBMIT THESE INSTRUCTION PAGES WITH YOUR APPLICATION AND SUPPORTING DOCUMENTS**
APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER

Application Fee $100 (NON-REFUNDABLE)

Checks returned for insufficient funds will be assessed a $40.00 service charge pursuant to O.C.G.A. §16-9-20. Applications valid for (1) one year

Additional License Types (currently or previously issued by any Georgia Professional Licensing Board): _______________________________________

Method Obtained by - Applicant is applying for above referenced license by:
( ) Examination
( ) Examination Waiver (only if you have already taken the Clinical exam thru ASWB)

Name __________________________________________________________
Legibly print your legal name (in order to be eligible to take the ASWB exam the name used on the license application must exactly match the name on the valid government issued I.D. used for identification of the ASWB exam.) Failure to comply with this will result in ASWB refusing test entrance to applicant.

Name as shown on exam records or transcripts (if different)

______________________________________________________________

Social Security Number _____/_____/_______ Date of Birth _____/_____/_______


Physical Address __________________________________________________

**Number and Street Apt. No City/State Zip

**(P.O. Box not acceptable – If you are granted a license, your name, mailing address and license number are public information and your mailing address will appear on the internet. Your physical address is required, if different than the mailing address. You must immediately notify the Board in writing of an address change).

Mailing Address __________________________________________________

Telephone Number - Day __________ Telephone Number - Night __________ Male ______ Female

*Email Address_____________________________________________________

***(Acknowledgement of your application will be sent by e-mail. Also, if any additional information is needed, e-mail is the most efficient way for the Board staff to contact you so that your application can be processed in the most efficient manner. Please notify the Board of any e-mail address change. YOUR E-MAIL ADDRESS WILL NOT BE SHARED WITH ANY THIRD PARTY).

☐ Please check this box if you are a military spouse or a transitioning service member of the United States armed forces (including the National Guard).
PART II - PROFESSIONAL BACKGROUND – ALL APPLICANTS

ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED LETTER OF EXPLANATION AND ALL SUPPORTING COURT OR OTHER DOCUMENTS.

☐ Yes ☐ No 1. Are you unable to practice safely as a result of use of alcohol or other drugs?

☐ Yes ☐ No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?

☐ Yes ☐ No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?

☐ Yes ☐ No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?

☐ Yes ☐ No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?

☐ Yes ☐ No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?

☐ Yes ☐ No 7. Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a "conviction" includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge(s). NOTE: The answer to this question is "YES" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.

If "yes," include a certified copy of the court records and final disposition from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact. Also include a personal letter of explanation regarding each incident. ALSO: Submit the "Background Investigation Consent" form found on the same webpage as this application with this application. Failure to submit this form with application may result in delayed processing of the application.

☐ Yes ☐ No 8. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?

☐ Yes ☐ No 9. Do you now hold or have you ever held a license as a social worker in any jurisdiction? If "yes" complete the following:

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>License No.</th>
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<tr>
<th>Date Issued</th>
<th>Expiration</th>
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</table>

Please request each licensing board submit verification of license to Georgia (Form N)

☐ Yes ☐ No 10. Have you previously applied for the same license for which you are currently applying? If "yes" name under which application was submitted:

☐ Yes ☐ No 11. Did you receive a Master's Degree in Social Work (MSW) from a Council on Social Work Education (CSWE) accredited school? Date Degree Received

<table>
<thead>
<tr>
<th>Name of School</th>
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☐ Yes ☐ No 12. Did you complete a practicum or internship as part of your MSW Degree Program?

☐ Yes ☐ No 13. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

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PART V - DIRECTED EXPERIENCE – EXAMINATION & EXAMINATION WAIVER APPLICATIONS

- List the name(s) of the Director(s) under whom you fulfilled the experience requirement for licensure and include the date(s) of employment AND total number of hours obtained from each place of employment.
- Have each Director complete a separate Form B — Professional Experience Verification Form to demonstrate that you meet the minimum experience requirement for licensure.
- See Board Rule Chapter 135-5-.04(5).
- This information listed here should match what is outlined on Form B.

| I hold a Master's Degree in Social Work AND a Doctoral Degree in: | Professional Counseling, Social Work, Marriage and Family Therapy, Medicine, Psychiatric Nursing, Applied Psychology, Pastoral Counseling or Applied Child and Family Development. My degree program included a Supervised Clinical Internship and I wish to substitute this for one (1) year of supervision. |

1. NAME OF DIRECTOR:

<table>
<thead>
<tr>
<th>DATES OF EMPLOYMENT</th>
<th>FROM:</th>
<th>TO:</th>
</tr>
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<tbody>
<tr>
<td>TOTAL NUMBER OF HOURS OBTAINED:</td>
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2. NAME OF DIRECTOR:

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## PART VI – SUPERVISION – EXAMINATION & EXAMINATION WAIVER APPLICANTS

**INSTRUCTIONS:**
- List the name(s) of the Supervisor(s) under whom you fulfilled the supervision requirement for licensure and include the date(s) of supervision AND total number of hours obtained by each supervisor.
- Have each Supervisor complete a separate Form C—Professional Experience Supervision Verification Form to demonstrate that you meet the minimum experience requirement for licensure.
- See Board Rule Chapter 135-5-.04
- This information listed here should match what is outlined on Form C

### NAME OF SUPERVISOR:

<table>
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<tr>
<th>DATES OF SUPERVISION</th>
<th>FROM:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>TOTAL NUMBER OF HOURS OBTAINED:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _______ I am a United States citizen 18 years of age or older. ATTACH a copy of your current Secure and Verifiable Document(s) such as driver’s license, passport, or other document as indicated from the list @ www.sos.ga.gov/plb.

2) _______ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number (See list @ www.sos.ga.gov/plb).

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists and/or criminal prosecution.

______________________________________________          __________________________
Signature of Applicant                                                           Date

Sworn to and subscribed before me this

_________ day of _______________________ 20_____

_______________________________________________                          ( Notary Seal)
Notary Public Signature

My Commission Expires: __________________________

NOTE to NOTARY: Application must be signed with Proper ID.
APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE
SOCIAL WORK DIRECTED EXPERIENCE VERIFICATION FORM - FORM B

- 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

<table>
<thead>
<tr>
<th>NAME OF APPLICANT:</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>(Maiden)</th>
</tr>
</thead>
</table>

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 ongoing 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 SOCIAL WORK AT:

__________________________ ________________________
(Name of Agency or Organization)

<table>
<thead>
<tr>
<th>Address:</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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

(MUST DOCUMENT DATE - DO NOT USE “PRESENT”)

Total Number of Hours: __________________________

__________________________ ________________________
(Date) (Signature of Director or Authorized Person)

__________________________ ________________________
(Name of Agency or Organization) (Printed Name of Director or Authorized Person Above)

__________________________
(Title/Position)

__________________________ _____________
(Street Address) _______________________

__________________________ _____________
(City) (State) (Zip Code)

Telephone: (     ) Fax: (     )
APPLICATION FOR CLINICAL SOCIAL WORK LICENSE
SOCIAL WORK SUPERVISION VERIFICATION FORM - FORM C

APPLICANT: THE GA BOARD WILL ONLY ACCEPT THIS FORM – DO NOT SUBMIT FORMS USED BY OR SUBMITTED TO ANOTHER STATE REGULATORY ENTITY

- Complete Part I and forward this form to each supervisor from the organization or agency in which you completed your supervision. Complete a separate form for each Clinical Supervisor listed in your application. Use this form to only verify Social Worker supervision. The information on this form should match what is outlined on Page 6 – Part VI of the application. If you need additional forms, you may photocopy this form.
- Please do not submit supervision logs unless directly requested by the Board.

CLINICAL SUPERVISOR

- The Clinical Supervisor must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.
- “Supervision” means the direct clinical review by a Supervisor for the purpose of training or teaching of a Social Worker’s interaction with a client. See Rule 135-5-04 (2) (b) 1.

PART I - APPLICANT

<table>
<thead>
<tr>
<th>NAME OF APPLICANT:</th>
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PART II - CLINICAL SUPERVISOR

I HEREBY CERTIFY THAT I SUPERVISED THE ABOVE-NAMED INDIVIDUAL IN THE PRACTICE OF SOCIAL WORK AS FOLLOWS:

INDIVIDUAL SUPERVISION:

Total Hours: | Hours Per Week: | From: | To: |
-------------|----------------|------|-----|

GROUP SUPERVISION:

Total Hours: | Hours Per Week: | From: | To: |
-------------|----------------|------|-----|

DESCRIPTION OF PRACTICE SUPERVISED:

I attest that I served as this Applicant’s Clinical Supervisor, as defined above, that this description is a true and accurate representation of my supervision of this Applicant, and I:

☐ Recommend ☐ Do Not Recommend this Applicant for licensure.

___________________________
Signature of Clinical Supervisor

Yrs of Experience After License Issued: | Printed Name: |
----------------------------------------|--------------|

Address: ____________________________________________________________

Street | City | State | Zip Code |
--------|------|-------|---------|

Telephone #: ( ) | Fax #: ( )

License Type: | License #: | State: | Original Licensure Issue Date: | Exp. Date: |
-------------|------------|-------|-------------------------------|----------|

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APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE
PERSONAL REFERENCE FORM
FORM D

INSTRUCTIONS: Please type or print legibly.

Applicants must have references from two (2) teachers or supervisors who are familiar with their experience in Social Work.

APPLICANT - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.

REFERENCE - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.

The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Name:

PART II - REFERENCE

Name: ________________________________________________

Address: ________________________________________________

Day Phone: (_______) Other Phone: (_______)

Relationship to Applicant:  □ Teacher  □ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: ___________________________ TO: ___________________________
Month/Day/Year Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:

Title: ________________________________________________
Agency/Institution: ________________________________________________
Address: ________________________________________________

RECOMMENDATION:  I □ Recommend  □ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:  [Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date __________________________  Signature of Reference __________________________
APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE
PERSONAL REFERENCE FORM
FORM D

INSTRUCTIONS:
- Please type or print legibly.
- Applicants must have references from **two (2) teachers or supervisors** who are familiar with their experience in Social Work.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.

The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

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<tbody>
<tr>
<td>Name:</td>
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<tr>
<th>PART II - REFERENCE</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Address: __________________________________________________________________</td>
</tr>
<tr>
<td>Day Phone: (       )</td>
</tr>
<tr>
<td>Relationship to Applicant:  □ Teacher  □ Supervisor</td>
</tr>
<tr>
<td>Dates of Teaching/Supervisory Relationship: FROM: ___________ TO: ___________ Month/Day/Year  Month/Day/Year</td>
</tr>
<tr>
<td>PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:</td>
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<tr>
<td>Title: ______________________________________________________</td>
</tr>
<tr>
<td>Agency/Institution: ____________________________________________</td>
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<tr>
<td>Address: _____________________________________________________</td>
</tr>
<tr>
<td>RECOMMENDATION: I □ Recommend  □ Do Not Recommend the Applicant for licensure.</td>
</tr>
<tr>
<td>ADDITIONAL COMMENTS: [Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]</td>
</tr>
<tr>
<td>Date _________________________________________________________</td>
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<tr>
<td>Signature of Reference _________________________________________</td>
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INSTRUCTIONS:

- Please type or print clearly.

The Directed Experience Supervisor must be:

APPLICANT:

- Make every effort to locate the as many of the Directed who provided your Directed Experience as necessary to document the required Directed Experience.
- You may show your diligence with returned mail, copies of letters, and 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.
- A Form E must be submitted separately to document directed work experience and supervision. Do not combine the hours on one form.

PART I - APPLICANT

NAME:

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

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:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>FROM</th>
<th>TO</th>
<th>TOTAL HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>4</td>
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</tbody>
</table>

Date ____________________________

Signature of Applicant

Sworn to and subscribed before me this

______ day of __________, __________.

______________________________
Notary Public

My Commission Expires: ________________

NOTARY SEAL

08-21-2018
**INSTRUCTIONS:**

- Please type or print clearly.

The Directed Experience Supervisor must be:

**APPLICANT:**

- Make every effort to locate the as many of the supervisors who provided your supervision as necessary to document the required supervision hours obtained.
- You may show your diligence with returned mail, copies of letters and 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.
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### PART I - APPLICANT

**NAME:** ______________________________________________________

### PART II - OATH

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Name of Supervisor: ____________________________________________

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

Name of Director ______________________________________________

at: ___________________________ __________________________________

Name of Clinical Supervisor Address City State Zip

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

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<thead>
<tr>
<th>YEAR 1 OR PART THEREOF</th>
<th>FROM:</th>
<th>TO:</th>
<th>TOTAL HOURS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>YEAR 2 OR PART THEREOF</td>
<td>FROM:</td>
<td>TO:</td>
<td>TOTAL HOURS:</td>
</tr>
<tr>
<td>YEAR 3 OR PART THEREOF</td>
<td>FROM:</td>
<td>TO:</td>
<td>TOTAL HOURS:</td>
</tr>
<tr>
<td>YEAR 4 OR PART THEREOF</td>
<td>FROM:</td>
<td>TO:</td>
<td>TOTAL HOURS:</td>
</tr>
</tbody>
</table>

____________________________________  __________________________________
Date Signature of Applicant

Sworn to and subscribed before me this __________ day of ______________, ______.

______________________________
Notary Public

My Commission Expires: ______________

**NOTARY SEAL**

**08-21-2018**
**VERIFICATION OF LICENSURE IN ANOTHER STATE**

**FORM N**

- Please type or print legibly. NOTE: The GA Board will also accept this verification of licensure on any form or format the issuing state(s) may utilize or prefer.
- **Applicant** - Complete Part I. Mail a form to the Board or Agency of each state or jurisdiction by which you are currently licensed or certified as a Social Worker.
- **State Licensure Board or Regulatory Agency** - Complete Part II. Then either Fax to 866-888-7127 or e-mail to ExamBoards-Healthcare@sos.state.ga.us

### PART I - APPLICANT

<table>
<thead>
<tr>
<th>Full Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Social Security #:</td>
</tr>
</tbody>
</table>

**GEORGIA LICENSE APPLIED FOR - CHECK ONLY ONE:**

- Master Social Worker
- Clinical Social Worker

<table>
<thead>
<tr>
<th>Jurisdiction:</th>
<th>License Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Title of License:</th>
<th>Date Issued:</th>
<th>Expiration Date:</th>
</tr>
</thead>
</table>

**TO WHOM IT MAY CONCERN**

I, the undersigned applicant, am applying for a license with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. I hereby consent to the release of any information, favorable or otherwise, which you may have concerning my license or practice. Please return the completed form directly to the Georgia Board at the above address.

______________

Date

___________________________

Signature of Applicant

### PART II - LICENSURE BOARD OR REGULATORY AGENCY CERTIFICATION

I, __________________________, Board Chair or Designated Official

of the _____________________________ (Name of Board or Regulatory Agency)

certify

that the information provided above by this applicant □ does □ does not conform with that in our record.

If “does not”, please explain: __________________________________________

According to our record, the applicant □ has □ has not been disciplined by this or any other Board, state agency, or professional organization. **If the applicant has been disciplined, please explain and attach a copy of the Order or Decree:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature of Board Chair/Designated Official</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Board</td>
<td>Street Address</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BOARD SEAL**

City/State/Zip Code