GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
https://sos.ga.gov/licensing-division-georgia-secretary-states-office

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.

PART I - APPLICANT

NAME OF APPLICANT: _____
First Middle Last (Maiden)

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 - 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.

_____ _____
Date 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: