



## LICENSURE as a CLINICAL SOCIAL WORKER (LCSW) by EXAMINATION Electronic Application Checklist Instructions

**IMPORTANT NOTICE:**

To expedite the processing of your ONLINE application for licensure as a **Licensed Master’s Social Worker (LMSW) by Examination**, please upload any documentations you are required to provide by using the new **documents** upload feature in the online application portal. Documents you wish to upload must be uploaded prior to submitting your online application fee.

Prior to **uploading or emailing** the enclosed forms and required supporting documentation to the Board for consideration, we recommend that you review the [Licensure Process Handbook](#), and the [Regulations Governing the Practice of Social Work](#) available on the Board’s website at [www.dhp.virginia.gov/social](http://www.dhp.virginia.gov/social) to ensure you are applying for the correct application type and have met the requirements for this application type. Pursuant to 18VAC140-20-30(B) of the [Regulations Governing the Practice of Social Work](#), all fees submitted to the Board are **non-refundable**.

A complete application packet provides the best opportunity to avoid delays in the application review process. You should make every effort to upload or email all the below information to the Board office for consideration. It is preferred that supporting documents be provided to the Board in **pdf file format**. Your application packet is **NOT** considered complete until all applicable supporting documentation has been received by the Virginia Board of Social Work.

CHECK MARK	CHECKLIST OF REQUIRED DOCUMENTATION	SUBMISSION METHODS TO THE BOARD
	<b>1. NATIONAL PRACTITIONER DATA BANK (NPDB) SELF-QUERY REPORT</b>	
<input type="checkbox"/>	A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be submitted. You may request a self-query report at <a href="https://www.npdb.hrsa.gov/">https://www.npdb.hrsa.gov/</a> .	<b>ONLINE</b>
	<b>2. VERIFICATION OF CLINICAL SUPERVISION</b>	
<input type="checkbox"/>	You must provide verification you have complete the supervised experience requirements. Please have the <b>Verification of Clinical Supervision Form</b> completed by your supervisor (s) verifying your supervised experience. <i>If you completed your hours under more than one Board-Approved supervisor, a <u>separate verification of clinical supervision form must be completed for each supervisor.</u></i>	<b>ONLINE</b>
	<b>3. OFFICIAL SCHOOL TRANSCRIPT</b>	
<input type="checkbox"/>	An <u>official</u> transcript (paper or electronic) showing proof of a <b>Master’s</b> degree from a school of social work accredited by the <a href="#">Council on Social Work Education</a> (CSWE) is required. For faster processing, it is encouraged that transcripts be electronically sent directly to the Board at <a href="mailto:socialwork@dhp.virginia.gov">socialwork@dhp.virginia.gov</a> via a <b>secured electronic transcript service</b> used by the school (for example: eScript or parchment). If your school is unable to send your transcript electronically, the official transcript must be <b>mailed</b> directly to the Board in a sealed envelope from the school. <b>Photocopied transcripts will not be accepted. All official transcripts must include a conferred date.</b> <i>If you have been previously approved by the Board for supervision, a duplicate transcript is not required.</i> <b>Foreign Educated ONLY:</b> Graduates of foreign institutions must establish the equivalency of their education through the Foreign Equivalency Determination Services of the <a href="#">Council on Social Work Education</a> (CSWE)	<b>E-MAIL or MAIL</b> (Preferably via E-mail & must come directly from the school/issuing institution)
	<b>4. VERIFICATION OF PRACTICUM/EDUCATION</b>	
<input type="checkbox"/>	You must provide verification of your practicum and clinical course of study. Please have the <b>Verification of Practicum/Education Form</b> completed by the graduate school program official or administration office and	<b>ONLINE</b>

	sent directly back to you and included in your application packet. <i>If you have been previously approved by the Virginia Board for supervision, a duplicate form is not required.</i>	
	<b>5. PROOF OF NAME CHANGE (if applicable)</b>	
<input type="checkbox"/>	Documentation must be provided to show each name change(s) if your name has ever been legally changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Acceptable forms of documentation include a copy of a marriage license, court order or divorce decree.	<b>ONLINE</b>
	<b>6. VERIFICATION OF LICENSURE/CERTIFICATION (if applicable)</b>	
<input type="checkbox"/>	If you have ever held a health or mental health license or certification, <b>whether current or expired</b> , please send the <b>Out of State Licensure Verification Form</b> to the issuing jurisdiction (s). This verification form should be completed by the issuing jurisdiction (s) and emailed directly back to the Virginia Board. <i>(Some jurisdictions charge a fee for this service. Check with that jurisdiction before sending the form.)</i>  <b>-or-</b>  You can provide an online verification from the licensing jurisdiction’s website if the website is considered <b>“primary source verified”</b> . The online verification must provide <b>all</b> of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.	<b>ONLINE or E-MAIL</b>
	<b>7. VERIFICATION OF LICENSURE for OUT-OF -STATE SUPERVISOR (if applicable)</b>	
<input type="checkbox"/>	If your supervisor did not hold a Virginia Clinical Social Work License at the time of your supervised experience, please have the <b>Verification of Licensure for Out-of-State Supervisor Form</b> completed. This verification form should be completed by the issuing jurisdiction and sent back to you and included in your application packet. Online verification printed from the licensing jurisdiction’s website are also accepted if the online verification provides <b>all</b> of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.	<b>ONLINE</b>
	<b>8. EXAM SCORES (if applicable)</b>	
<input type="checkbox"/>	If you have already passed the <b>CLINICAL</b> level examination administered by the Association of Social Work Boards (ASWB) in another state your official scores are required to be transferred to Virginia. To request a score transfer from ASWB, see the exam section on their website at <a href="https://www.aswb.org/">https://www.aswb.org/</a> .	<b>E-MAIL</b> (Directly from ASWB)
	<b>9. CRIMINAL CONVICTIONS, PAST ACTIONS or POSSIBLE IMPAIRMENTS (if applicable)</b>	
<input type="checkbox"/>	If you answer “YES” to any of these questions on your application, please include a detailed explanation <b>and</b> supporting documentation. <i>Please refer to <a href="#">Guidance Document 140-2</a>, available on the Board’s website, for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments.</i>	<b>ONLINE</b>

#### GENERAL INFORMATION

- Applications are processed in the order received. Please allow adequate processing time for applications. Applications that are complete, fully documented and meet the minimum requirements for the [Regulations Governing the Practice of Social Work](#) will be reviewed within **30 days** of receipt of a **complete** application packet.
- Periodically log into the DHP license application portal at: <https://www.license.dhp.virginia.gov/apply/Login.aspx> to monitor progress of your application and remember “unchecked” items may have been received but are pending review.
- Check your license status by going to: [License Lookup](#) (\*license information is posted in real time).
- Please notify the Board in writing within 30 days of a name change or address change by completing the **Name/Address Change Form** available on the Board’s website at [www.dhp.virginia.gov/social](http://www.dhp.virginia.gov/social).
- An incomplete application for licensure will be retained on file for one (1) year. If not completed within one year of receipt, a new application and fee will be necessary.
- Providing false or misleading information as well as omitting information in response to information requested in the application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing registration or license.

- Pursuant to [Virginia Code § 54.1-2400.02](#) addresses of licensees/supervisees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publically available, please complete both sections with same address on the application.
- Pursuant to [Virginia Code § 54.1-116 \(A\)](#), you are required to submit your social security number or your control number issued by the *Virginia* Department of Motor Vehicles\*. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities. **NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FALIED TO DISCLOSE ONE OF THESE NUMBERS.**

*End of instructions*



Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463

Email: [socialwork@dhp.virginia.gov](mailto:socialwork@dhp.virginia.gov)  
Phone: (804) 367-4441 E-Fax: (804) 977-9915  
Website: [www.dhp.virginia.gov/social](http://www.dhp.virginia.gov/social)

## VERIFICATION of CLINICAL SUPERVISION

### IMPORTANT NOTICE:

The applicant should complete the top portion of this form **only**, then provide this form to the supervisor who supervised the applicant's post-master's degree experience. The completed form should be returned to the applicant for inclusion in their application packet that must be sent to the Virginia Board of Social Work. **If supervision took place under more than one Board-approved supervisor, a separate form is required for each supervisor.**

**TO BE COMPLETED BY APPLICANT/SUPERVISEE:** Complete the top portion of this form **only**.

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Email Address:		Phone Number: ( ___ ___ ___ ) ___ ___ ___ - ___ ___ ___	

**TO BE COMPLETED BY SUPERVISOR:**

### Part I: Supervisor's Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Email Address:		Supervisor's Phone Number: ( ___ ___ ___ ) ___ ___ ___ - ___ ___ ___	

### Part II: Worksite Information (location where supervisee obtained post-master's degree experience hours toward licensure)

Name of Worksite:		
Address of Worksite:		
City:	State:	Zip Code: _____

### Part III: Dates of Supervision

Start Date: (MM/DD/YYYY) ___ / ___ / _____	End Date: (MM/DD/YYYY) ___ / ___ / _____	Total Months: _____
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**Part IV: Hours & Competencies** (Answers to the below questions should be provided based on the supervision obtained **only** under the instructions of the supervisor completing this form. If the response is "NO" to any of the below questions, please provide an explanation on a separate sheet of paper and provide it with this form to the applicant.)

	<input type="checkbox"/> YES Exact # of Hours Obtained		<input type="checkbox"/> NO If not, how many hours	
	Individual	Group	Individual	Group
a. Did the applicant receive a minimum of one (1) hour and a maximum of four (4) hours of face-to-face supervision per 40 hours of work experience for a total of at least <b>100</b> hours with no more than 50 of the 100 hours obtained in group supervision while under your supervision? <b>(Do not include hours obtained under another supervisor)</b>				
b. Did the applicant complete a minimum of <b>3,000</b> hours of supervised post-master's degree experience in the delivery of "clinical social work services" and in ancillary services that support such delivery while under your supervision? <b>(Do not include hours obtained under another supervisor)</b>				
c. Did the applicant obtain throughout their hours of supervision a minimum of <b>1,380</b> hours of supervised experience in face-to-face client contact in the delivery of "clinical social work services" while under your direct supervision? <b>(Do not include hours obtained under another supervisor)</b>				
d. Did the applicant demonstrate minimum competencies of <b>identified theory base</b> while under your supervision?				
e. Did the applicant demonstrate minimum competencies of <b>application of a differential diagnosis</b> while under your supervision?				

f. Did the applicant demonstrate minimum competencies of <b>establishing and monitoring a treatment plan</b> while under your supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Did the applicant demonstrate minimum competencies of <b>development and appropriate use of the professional relationship</b> while under your supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Did the applicant demonstrate minimum competencies of <b>assessing the client for risk of imminent danger</b> while under your supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Did the applicant demonstrate minimum competencies of <b>implementing a professional and ethical relationship with clients</b> while under your supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. Did the applicant demonstrate minimum competencies of <b>understanding the requirements of law for reporting any harm or risk of harm to self or others</b> while under your supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
k. In your opinion, has the applicant demonstrated competency sufficient for licensing and the independent practice as a clinical social worker?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Part V: Declaration of Supervisor**

I, \_\_\_\_\_ (name of supervisor) declare by my signature, to the best of my knowledge the foregoing is true and correct.

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

**ORIGINAL, ELECTRONIC OR E-SIGNATURE REQUIRED**

## APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

**IMPORTANT NOTICE:**

This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant a health or mental health license or certification. **The Applicant should complete Part I of this form ONLY.** The State Board should complete Part II of this form. The completed form should be returned to the applicant for inclusion in their application packet to be sent to the Virginia Board of Social Work **or** the State Board can send the form electronically to the Virginia Board at [socialwork@dhp.virginia.gov](mailto:socialwork@dhp.virginia.gov)

**TO BE COMPLETED BY APPLICANT:** Complete the top portion **only** and send this form to the jurisdiction (s)/State Board (s) that issued you a health or mental health license or certification (**fee may be required**).

**Part I. Applicant's Identification & Contact Information**

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Last 4 digit of Social Security Number: XXX-XX- ____		Date of Birth: (MM/DD/YYYY) ____ / ____ / ____	
Address:			
City:	State:	Zip Code:	
Email Address:			

**TO BE COMPLETED BY STATE BOARD:** Please provide official verification of applicant's licensure information requested below and email completed form to applicant or **directly** to the Virginia Board of Social. **If emailing this form directly to the Virginia Board, please use the subject line: Applicant Licensure Verification (ref: Applicant's Name)**

**Part II. Applicant's Licensure Information**

Title of License:	License Number:
Issue Date: (MM/DD/YYYY) ____ / ____ / ____	Expiration Date: (MM/DD/YYYY) ____ / ____ / ____
License Obtained by: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> Reciprocity <input type="checkbox"/> Grandfathered <input type="checkbox"/> other _____	
Status of License: <input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive <input type="checkbox"/> other _____	
Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? <i>If yes, please attach certified copy of order issued by State Board.</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>
I certify the above information to be true in every respect, according to the record on file with the _____ (Title of Board)	
Name of Authorized Licensure Official: _____	
Title of Authorized Licensure Official: _____	
Telephone Number: _____	
Email Address: _____	
Date: _____	

**STATE SEAL**



## VERIFICATION OF EDUCATION & FIELD PLACEMENT/PRACTICUM HOURS

**IMPORTANT NOTICE:**

Pursuant to 18VAC140-20-49(B) of the [Regulations Governing the Practice of Social Work](#), this form should be used and completed by the graduate school program official or administration office to verify the applicant's clinical course of study and field placement/practicum. The completed form should be returned to the applicant for inclusion in their application packet that must be sent to the Virginia Board of Social Work.

<b>TO BE COMPLETED BY APPLICANT:</b> Complete the top portion of this form <u>only</u> .			
Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Date of Birth: (MM/DD/YYYY) __ __ / __ __ / __ __ __ __		Last 4 digits of Social Security Number: XXX-XX-__ __ __ __	
Applicant's Student ID Number:		Email Address:	

**TO BE COMPLETED BY GRADUATE SCHOOL PROGRAM OFFICIAL OR ADMINISTRATIVE OFFICE:** Please provide official verification of information requested below. The completed form containing **original or electronic** signature should be returned to the applicant for inclusion in their application packet being mailed to the Virginia Board of Social Work.

**Part I:**

Did the above applicant complete a minimum of **600 hours** of **advanced** clinical practicum that focused on diagnostic, prevention, and treatment services?

Yes     No **(If not, how many hours? \_\_\_\_\_)**

Did the above applicant's field placement/practicum supervisor hold a licensed clinical social worker (LCSW) license **or** hold a master's or doctorate degree in social work with a minimum of three years of experience in clinical social work services after earning a graduate degree set forth in Regulation 18VAC140-20-49 of the Virginia Regulations?

Yes     No **(If not, explain on separate page)**

**Part II:** Please verify if the following **advanced** coursework was **successfully** completed by the applicant as part of a "clinical course of study?" **(Check all that apply)**

<input type="checkbox"/> Human Behavior and the Social Environment	<input type="checkbox"/> Social Justice and Policy
<input type="checkbox"/> Psychopathology	<input type="checkbox"/> Diversity Issues
<input type="checkbox"/> Research	<input type="checkbox"/> Clinical Practice with Individuals, Families and Groups

Printed Name of School \_\_\_\_\_

Printed Name of Program Official \_\_\_\_\_

Title of Program Official \_\_\_\_\_

Signature of Program Official \_\_\_\_\_ Date \_\_\_\_\_

**ORIGINAL, ELECTRONIC OR E-SIGNATURE REQUIRED**





## SUPERVISOR'S OUT-OF-STATE LICENSURE VERIFICATION

**IMPORTANT NOTICE:**

This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant's supervisor a license/certification to practice social work. **The Applicant should complete Part I & II of this form ONLY.** The State Board should complete Part III of this form. The completed form should be returned to the applicant for inclusion in their application packet to be sent to the Virginia Board of Social Work **or** the State Board can send the form electronically to the Virginia Board at [socialwork@dhp.virginia.gov](mailto:socialwork@dhp.virginia.gov)

**TO BE COMPLETED BY APPLICANT:** Complete **Parts I & II only**, then send this form to the Board of Social Work in the state(s) where your **supervisor** was licensed as a Clinical Social Worker (**fee may be required**).

**Part I. Applicant's Identification & Contact Information**

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Last 4 digit of Social Security Number: XXX-XX- ____ - ____		Date of Birth: (MM/DD/YYYY) ____ / ____ / ____ - ____	
Address:			
City:	State:	Zip Code: ____ - ____ - ____	
Email Address:			

**Part II. (Supervisor's Information to be verified)**

Supervisor's Last Name:	First Name:	Middle/Maiden Name:	Suffix:
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**TO BE COMPLETED BY STATE BOARD OF SOCIAL WORK:** Please provide official verification of applicant's supervisor's licensure information requested below and mail or email completed form to applicant or **directly** to the Virginia Board of Social. **If emailing this form to the Virginia Board, please use the subject line: Supervisor Licensure Verification (ref: Applicant's Name)**

**Part II. Supervisor's Licensure Information**

Title of License:	License Number:
Issue Date: (MM/DD/YYYY) ____ / ____ / ____ - ____	Expiration Date: (MM/DD/YYYY) ____ / ____ / ____ - ____
License Obtained by: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> Reciprocity <input type="checkbox"/> Grandfathered <input type="checkbox"/> other _____	
Status of License: <input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive <input type="checkbox"/> other _____	
Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? <i>If yes, please attach certified copy of order issued by Board of Social Work</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>

I certify the above information to be true in every respect, according to the record on file with the \_\_\_\_\_ (Title of Board)

Name of Authorized Licensure Official: \_\_\_\_\_

Title of Authorized Licensure Official: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date: \_\_\_\_\_

**STATE SEAL**