Mike Beebe
Governor

STATE OF ARKANSAS
SOCIAL WORK LICENSING BOARD

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Supervision Plan

This plan must be submitted to the Board within 60 days from the beginning date of supervision.

Supervisee Information:

Name: _____ License Number: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____

Employment Address: _____

Work Schedule: _____ Full-time _____ Part-time (Total hours employed in a social work position must equal 4,000 hrs.)

Are you and the supervisor employed by the same agency? _____ Yes _____ No If no, you must attach a letter from the agency supervisor or administrator stating that the supervisor has access to the pertinent records and/or policies.

Supervisor Information:

Name: _____ License Number: _____

Place of Employment: _____

Employment Address: _____

Supervision Schedule:

Beginning Date of Supervision: _____

Supervision Format: _____ Individual _____ Group _____ Combination Group supervision is acceptable only if there is a maximum of four in the group, and such supervision does not exceed one-half of the total supervisory time.

Supervision Sessions Per Month: _____ Hours Individual _____ Hours Group _____ Total

Methods of Supervision: _____ Direct observation _____ Chart audits _____ Peer review _____ Other

If other, please explain _____

_____

Supervision Process:

Describe the supervisee's work setting(s): _____

_____

Describe the clients served: _____

_____

Describe the supervisee's duties and responsibilities including treatment methods utilized: _____

_____

_____

Formulate five goals for the supervision:

1. _____
2. _____
3. _____
4. _____
5. _____

Comments: _____

_____

_____

Attachment to include with Supervision Plan:

_____ If the supervision of agency-based clients is done outside the agency setting, a letter from the agency supervisor or administrator must be attached. The letter must state that the supervision is approved and that the LCSW supervisor has access to the pertinent records and/or policies.

Affidavit of Understanding and Signatures:

_____ I hereby certify that prior to beginning supervision I have received and reviewed the regulations and forms pertaining to LCSW supervision. I understand that I must observe and comply with the supervision guidelines set forth in the rules.

Under penalties of perjury, I declare and affirm that the statements made in the supervision plan, including accompanying statements, are true, complete and accurate. I understand that any false or misleading information in, or in connection with my supervision plan may be cause for denial or loss of supervision time received/and or loss of licensure.

Supervisee Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____

The *original* of this form and any attachment(s) must be mailed by the supervisee to the Social Work Licensing Board, P. O. Box 250381, Little Rock, AR 72225 *within 60 days of beginning supervision*. Forms received after 60 days will not be accepted.