Asa Hutchinson
Governor

STATE OF ARKANSAS

SOCIAL WORK LICENSING BOARD

Mailing Address:
PO Box 251965
Little Rock, AR 72225

Street Address:
2020 West Third, Suite 518
Little Rock, AR 72205

Ruthie Bain
Executive Director
Phone 501-372-5071
Email: swlb@arkansas.gov
Website: arkansas.gov/swlb

INSTRUCTIONS: Read the Supervision Guidelines, The **ORIGINAL** of this plan must be submitted to the Board within ***60-days*** from the beginning date of supervision. Keep a copy for your records. The Board does not send confirmation of receipt. You may request a confirmation of delivery from the Post Office or you can follow-up with the Board's office by email or phone call to make sure the Plan has been received. Please use updated forms and keep a copy for your records.

Supervision Plan

Supervisee Information:

Name: ____ License Number: ____________________

Home Address: (full) ____
(Please note: If this has changed you must submit a change of address form – available on website.

Home Phone:_________________ Cell Phone:____________________ Email:________________________

Place of Employment: _________________________________ Work Phone: _______________________

Employment Address: (full)____

Job Title:____ Work Email:________________________________

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: ____

Home Address: (full) ____

Home Phone:____________________________ Cell Phone:______________________________________

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 ____

____

Continued on next page – below this line for board use only

Plan reviewed by:________________________ Date:______________ Plan Received on:____________
Board Member Signature

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. I understand I must submit the original of this form within 60-days of beginning supervision.

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 251965, Little Rock, AR 72225 *within 60 days of beginning supervision*. Forms received after 60 days will not be accepted.