



**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.