

VERIFICATION OF SUPERVISION
(PROFESSIONAL REFERENCE ASSESSMENT)

THIS SECTION TO BE FILLED OUT BY APPLICANT:

License Number (LMSW) _____
Effective Date _____ / _____ / _____
Expiration Date _____ / _____ / _____

Applicant's Name _____

I have applied to the Tennessee Board of Social Worker Licensure to become a licensed clinical social worker. Your assessment of my characteristics will enable the board to evaluate whether I meet their standards.

(Signature)

(Date)

REMAINDER OF THIS FORM TO BE FILLED OUT BY SUPERVISOR .

1. Supervisor's Name: _____

Profession: _____ Educational Degree(s): _____

Business address (street/city/state/zip): _____

Position Title: _____ Telephone: (_____) _____

2. Supervisor's License No.: _____ Licensing State: _____

Date Licensed: _____

Clinical experience: Yes ___ No ___ Number of years: _____

3. Recordkeeping: Dates of Supervision: from _____ / _____ / _____ to _____ / _____ / _____

Total number of months of supervision _____

Total weekly clinical contact hours _____

Total weekly supervisor-supervisee hours _____

Total weekly group supervisee-supervisor hours _____

1. Total clinical hours during supervision period _____

2. Total supervisor-supervisee hours during supervision period _____

3. Group supervisee-supervisor hours during supervision period _____

(Add #2 and #3) Total number hours of supervision _____

4. Nature of setting in which supervised practice took place:

5. Please rate the applicant on the following characteristics. Place a check mark in every category!

Characteristics	Outstanding	Above Average	Average	Below Average	Can Not Evaluate
Individual counseling skills					
Appropriate referral making					
Group counseling skills					
Personal integrity					
Consulting skills					
Insight into client's problems					
Ability to relate to co-workers					
Ability to be objective on the job					
Ethical conduct					
Concern for welfare of clients					
Sense of responsibility					
Recognition of own limits					
Supervisory abilities					
Ability to keep material confidential					

6. Explain any rating of below average, poor, or can not evaluate (use additional paper if necessary).

I certify that the information contained herein is an accurate account of my supervision of:

 (Applicant Signature)

 (Supervisor's Signature)

 (Date)

 (Print Name of supervisor)

Return completed form to applicant or:

**Board of Social Worker Licensure
 665 Mainstream Drive
 Nashville, TN 37243**

This Form May Be Duplicated