

**STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS
AND PROFESSIONAL COUNSELORS**

P.O. BOX 2649
HARRISBURG, PA 17105-2649

Email st-socialwork@pa.gov

www.dos.pa.gov/social

**APPLICATION FOR A LICENSE BY EXAMINATION TO PRACTICE CLINICAL SOCIAL WORK
(THIS APPLICATION MUST BE SUBMITTED FOR PRE-APPROVAL TO TAKE THE ASWB CLINICAL
EXAMINATION)**

QUALIFICATIONS FOR LICENSURE AND TO TAKE THE ASWB CLINICAL EXAMINATION:

(Satisfactory Proof must be submitted to the Board that all of the following have been met)

1. Application fee- \$45.00 and is non-refundable. Check/money order should be made payable to "Commonwealth of PA". A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for nonpayment. If the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application (another application processing fee) and supporting documents as necessary.
2. Hold a Master's Degree in social work or social welfare from a school which is accredited by the Council on Social Work Education **OR** a Doctoral Degree in Social Work from a school of social work which is accredited.
3. International graduates must request the Council on Social Work Education (CSWE) send a credential evaluation directly to the Board at the above address.
4. Holds a current license as a social worker in the Commonwealth of PA.
5. Completed 3000 hours of supervised clinical experience as set forth in section 47.12c(b) or 47.12c(c) of the Board's regulations **after** completing the Master's Degree in Social Work. As per Section 47.12c(b)(2) 1500 hours shall be supervised by a supervisor meeting the qualifications in Section 47.1a(1) and, if experience was completed prior to January 1, 2006, Section 47.1a(1) or (3). No more than 1500 hours may be supervised by an individual meeting the requirements of Section 47.1a(2). **Pages 3, 4 and 5 of the supervised clinical experience form must be received by the supervisor(s) in a sealed envelope.** **OR** If you hold current certification from the Academy of Certified Social Workers (ACSW) issued prior to January 1, 2001, by the National Association of Social Workers, a letter will need to be submitted by the National Association of Social Workers (National Headquarters) verifying current ACSW certification. As long as the ACSW certification meets the requirements indicated above, the certification will be accepted in lieu of the 3000 hours of supervised clinical experience.
6. Please provide a curriculum vitae (a list of activities from graduation to the present.)
7. Passed the Clinical Examination of the Association of Social Work Boards (ASWB formerly AASSWB). **If you have already taken and passed the ASWB Clinical Examination request your scores to be sent DIRECTLY to the Board from ASWB.**
8. If licensed in another state, request each state licensing agency where you have ever held a license to practice (active, inactive, expired, etc..) to send a letter of good standing **DIRECTLY** to the Board office in an official sealed state board envelope.

9. If documents will be submitted to the Board under a name different from your present name, submit a copy of legal document showing the name change (marriage certificate, divorce decree, court order, etc..)
10. The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. [Child Abuse Continuing Education Providers Information can be found here.](#)
11. **Effective July 1, 2016**, provide a Self-Query from the National Practitioner Data Bank completed within 6 months of submission of this application to the Board. A Self-Query can be requested online at <https://www.npdb.hrsa.gov/>. When you receive the "Self-Query Response" from the National Practitioner Data Bank, forward it to the Board office. (Verify that "Self-Query Response" is sent to the Board and not a discrepancy notice.)
12. **Effective July 1, 2016**, an official Criminal History Record Check (CHRC) from the state agency for every state in which you have resided for the past 5 years. The report(s) must be dated within 90 days of the date of your application for licensure by examination. This report can be sent to you and forwarded to the Board with your application. For Pennsylvania CHRC, this can be done online at <http://epatch.state.pa.us>. **For states that do not provide CHRC for employment or licensing purposes (CA & AZ)**, we will accept an FBI background check. Please go to <https://www.fbi.gov/about-us/cjis/identity-history-summary-checks> and obtain your Federal Bureau of Investigation (FBI) Identity History Summary Check.

PLEASE NOTE:

If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee.

In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance. All background check documents cannot be older than 90 days from the date of issuance.

STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS
AND PROFESSIONAL COUNSELORS

Email: st-socialwork@pa.gov

Website: www.dos.pa.gov/social

Mailing address

P.O. BOX 2649
HARRISBURG, PA 17105-2649

Courier Delivery Address:

2601 North Third Street
Harrisburg, PA 17110

APPLICATION FOR A LICENSE BY EXAMINATION
TO PRACTICE CLINICAL SOCIAL WORK

PLEASE INDICATE IF YOU NEED TO TAKE THE ASWB CLINICAL EXAMINATION BELOW:

() YES () NO () EXTENSTION

Application fee- \$45.00 and is non-refundable. Check/money order should be made payable to "Commonwealth of PA". A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for nonpayment.

Name: _____
Last First Middle Maiden

Address: _____
Street

_____ City State Zip

Current PA Social Work License Number _____ Applicant's Email _____

Social Security Number: _____ Date of Birth: _____
Month Day Year

School of Social Work: _____

Address of School: _____
City State Zip

Date of Graduation: _____
Month Day Year

NAME AS IT APPEARS ON DIPLOMA OR DEGREE (If transcript will be submitted under a different name from the name listed on the above, submit a copy of legal documenting showing the name change (marriage certificate, divorce decree, court order, etc..))

Please list all states, in which you have lived in the past five years: _____

If you have already taken the ASWB clinical exam, please provide the date of **clinical** examination by ASWB

(AASSWB): _____
Month Day Year

The following questions must be answered, please check the appropriate box.	Yes	No
1. Do you hold or have you held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction? If yes, please list all professions and states where you have been licensed and request a letter of good standing be sent from each state board to the Pennsylvania Board. _____		
2. Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
3. Do you currently have any disciplinary charges pending against your professional or occupational licensure, certificate, permit or registration in any state or jurisdiction?		
4. Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5. Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6. Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7. Do you have any mental or physical condition that would prevent you from practicing social work with reasonable skill? If yes, please provide a written explanation on an 8 ½ x 11 sheet of paper.		
8. Have you ever been found guilty of immoral or unprofessional conduct?		
9. Have you ever violated standards of professional practice or conduct?		
10. Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination.		
11. Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
13. Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?		
14. Have you ever been charges by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		

IF YOU HAVE ANSWERED YES TO ANY QUESTIONS FROM 2 THROUGH 13, PLEASE ATTACH AN 8 ½ X 11 SHEET OF PAPER EXPLAINING THE SITUATION IN DETAIL. INCLUDE COURTHOUSE CERTIFIED COPIES OF ANY DOCUMENTS EXPLAINING THE SITUATION, IF APPLICABLE.

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties form tampering with public records or information under 18 Pa.C.S. § 49.11. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

 APPLICANT'S SIGNATURE

 DATE

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Regular address: State Board of Social Workers, Marriage and Family Therapists and Professional Counselors PO Box 2649 Harrisburg, PA 17105-2649

Courier Delivery: State Board of Social Workers, Marriage and Family Therapists and Professional Counselors 2601 North Third Street Harrisburg, PA 17110

The information on these forms must be provided by the applicant's supervisor that provided the supervision for the supervised clinical experience hours completed towards meeting the 3000 hours of supervised clinical experience defined in Section 47.12c(b) and Section 47.12d of the regulations. This verification of supervised clinical experience form should be photocopied then completed by each supervisor that provided supervision towards the 3000 hours of supervised clinical experience. If there are gaps in dates greater than 1 month during the supervised clinical experience being completed, separate forms must be completed after each gap in dates.

Hours required: 3,000 hours of supervised clinical experience that meet the requirements defined in Sections 47.12c(b) and 47.12d of the regulations. 1,500 hours must be face-to-face direct client contact in person. The other 1,500 hours may be other non-direct clinical work determined by the supervisor.

YOUR SUPERVISOR (as defined in the rules and regulations) MUST COMPLETE THE FOLLOWING PAGES (4, 5 and 6) VERIFYING COMPLETION OF 3000 HOURS OF SUPERVISED CLINICAL EXPERIENCE AFTER COMPLETING YOUR MASTER'S DEGREE IN SOCIAL WORK.

Applicant's Name: _____ Last First Middle

Supervisor's qualifications: Please check all that apply.

1500 hours of supervised clinical experience must be completed under an individual that meets the requirements of Section 47.1a(1) and if the supervised clinical experience was completed prior to January 1, 2006, may be completed under an individual that meets the requirements of Section 47.1a(3).

- Hold a license as a clinical social worker and have 5 years of experience within the last 10 years as a clinical social worker (Section 47.1a(1)).
Hold a license and a master's or doctoral degree in a related field, and have 5 years of experience within the last 10 years in that field (Section 47.1a(2)). Only 1500 hours of supervised clinical experience may be completed under a supervisor meeting this qualification.
Practices as a clinical social worker. Have 5 years experience within the last 10 years as a clinical social worker. Hold a license to practice as a social worker (Section 47.1a(3)). This qualification is for supervised clinical experience completed prior to January 1, 2006.

Supervisor's Name: _____ Please print

Supervisor's Address: _____ Street

City State Zip

License Number _____ Profession _____ State _____

(Pages 3, 4 and 5 must all be placed in a sealed envelope by the supervisor and the supervisor shall sign her/his name over the flap and the sealed envelope given to the applicant to submit.)

Where did the Clinical Experience occur:

Site: _____
Please print

Address: _____
Street

City State Zip

Dates of Supervised Experience: ____ / ____ / ____ to ____ / ____ / ____
month day year month day year

Number of weeks worked in which clinical experience was accrued between the dates listed above: _____

Total Number of Hours of Supervised Clinical Experience Worked with this Supervisor between the dates listed above: _____
(Do not include vacation days, sick days, etc..)

The total number of hours of face-to-face direct client contact hours completed: _____

Average Hours per week Applicant worked: _____

Dates of Individual supervised clinical experience: ____ / ____ / ____ to ____ / ____ / ____
month day year month day year

I provided _____ hour(s) of individual supervision for every 40 hours worked.

Dates of Group supervised clinical experience: ____ / ____ / ____ to ____ / ____ / ____
month day year month day year

I provided _____ hour(s) of group supervision for every 40 hours worked.

As per Section 47.12c(b) (1) At least one-half of the experience shall consist of providing services in one or more of the following areas:

Please check all that apply

- (i) Assessment
- (ii) Psychotherapy
- (iii) Other psychosocial-therapeutic interventions
- (iv) Consultation
- (v) Family therapy
- (vi) Group therapy

(Pages 3, 4 and 5 must all be placed in a sealed envelope by the supervisor and the supervisor shall sign her/his name over the flap and the sealed envelope given to the applicant to submit.)

As per Section 47.12c(b)(5) The supervisor, or one to whom supervisory responsibilities have been delegated, shall meet with the supervisee for a minimum of 2 hours for every 40 hours of supervised clinical experience. At least 1 of the 2 hours shall be with the supervisee individually and in person, and 1 of the 2 hours may be with the supervisee in a group setting and in person.

As per Section 47.12c(b)(9) The supervised clinical experience shall be completed in no less than 2 years and no more than 6 years, except that no less than 500 hours and no more than 1,800 hours may be credited in any 12-month period.

I verify that _____ has met the requirements of Sections 47.12c(b)(5) and 47.12c(b)(9) of the regulations.

I verify that I have reviewed and understand Sections 47.12c(b) and 47.12d of the regulations. I further verify that the supervised clinical experience documentation completed on these forms was completed based on my records and will provide the records upon request by the Board.

I verify that the statements in this verification of Clinical Supervised Experience are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license. I also verify that I have complied with Section 47.12d of Title 49 Standards for supervisors.

Signature of Supervisor

Date

(Pages 3, 4 and 5 must all be placed in a sealed envelope by the supervisor and the supervisor shall sign her/his name over the flap and the sealed envelope given to the applicant to submit.)