



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF CLINICAL SOCIAL WORK EXAMINERS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

**APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER
INSTRUCTION SHEET**

- Submit completed, signed and notarized application form.
- Enclose [processing fee](#) by check or money order payable to the "State of Delaware."
- Arrange for your supervisor to complete and sign the *Supervisory Reference Form* included in the packet. Your supervisor must send it *directly* to the Board.
 - The form must clearly show the number of post-MSW degree clinical social work hours.
 - The clinical experience must consist of at least 3200 hours, of which 1600 must be under professional supervision acceptable to the Board.
 - The supervisor(s) must be a licensed clinical social worker (LCSW), master of social work (MSW), licensed psychologist, or a licensed psychiatrist.
- If you currently hold, or have ever held, a social work license in another state, submit verification of licensure in good standing from *each* state where you have held a license, sent *directly* to the Board office from the other state.
- Arrange for your college or university to send an official transcript of your completed Masters degree *directly* to the Board office.
 - The college or university must be accredited by the Council on Social Work Education (www.cswe.org).
- If you have already taken and passed the ASWB clinical examination, request ASWB to send a certified statement of your passing score on the examination to the Board office. To request the score report, visit www.aswb.org.
- If you have *not* passed the examination, the Board office will notify you when you are approved to take the exam. You must then register for the examination. For more information about the examination, visit www.aswb.org.
 - When you are approved to sit for the examination, you have two years from the date of your application to pass. If you have not yet passed when the two years elapse, you must re-apply.
 - When the Board office receives the passing exam scores from ASWB, your license will be issued.



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TYPE OF APPLICATION

1. Indicate the type of application you are filing (check one):

- I am applying to take the ASWB clinical examination.
- I have passed the ASWB clinical examination *but* I do not hold a current **clinical license** in another State. (Check this one if you don't hold any current license or if you hold a license but it is not a **clinical** license.)
- I hold a current **clinical license** and am applying for licensure by reciprocity from the State of _____.

IDENTIFYING AND CONTACT INFORMATION

2. Name (no titles, credentials, etc.): _____
Last First Middle

3. Any Other Name(s) Used: _____ 4. Date of Birth: _____
Month/Day/Year

5. Mailing Address: _____
Street

City State Zip

6. Home Telephone: _____ Work Telephone: _____

7. Email: _____

8. Have you been issued a U.S. Social Security Number? Yes No
- If yes, enter your SSN: _____
 - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

EDUCATION

9. Enter the following information about your graduate education.

Degree	Date Awarded	Name of Institution Granting Degree

Arrange for your college or university to send an official transcript of your completed Masters degree *directly* to the Board office.

LICENSURE HISTORY & PROFESSIONAL EXPERIENCE

10. Have you ever held a license in any other state(s)? Yes No If yes, enter the following information about *each* license:

State	License Number	Issue Date	Status (e.g., active)

Arrange for the Board office to receive verification of licensure *directly* from *each* state in which you are now, or have ever been, licensed.

11. List your professional clinical social work experience ***after your Master’s degree was conferred.*** Begin with the most recent experience and work backward. *“From” dates must not precede the date your degree was conferred.* List the total number of hours worked, not the number of hours worked per week. If needed, use this same format on additional sheets. Do not submit resumes.

From _____ To _____ Total Number of Hours: _____
 Employer: _____
 Address: _____
 Supervisor’s Name: _____
 Supervisor Title/Professional Status: _____ Telephone: _____
 Your Position/Title: _____
 Job Responsibilities and Activities (use additional page if needed): _____

From _____ To _____ Total Number of Hours: _____
 Employer: _____
 Address: _____
 Supervisor’s Name: _____
 Supervisor Title/Professional Status: _____ Telephone: _____
 Your Position/Title: _____
 Job Responsibilities and Activities (use additional page if needed): _____

From _____ To _____ Total Number of Hours: _____
 Employer: _____
 Address: _____
 Supervisor’s Name: _____
 Supervisor Title/Professional Status: _____ Telephone: _____
 Your Position/Title: _____
 Job Responsibilities and Activities (use additional page if needed): _____

12. List present or former clinical supervisors who are able to verify your required post-Master's degree supervision:

Name	Address	Telephone	License #

DISCLOSURES

- 13. Have you ever been convicted of or entered a plea of guilty or nolo contendere (no contest) to any felony, misdemeanor, or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes No **If yes, submit a certified copy of your criminal history record.**
- 14. Have there ever been, or are there now any pending professional disciplinary actions against you? Yes No **If yes, attach an explanation in full detail by giving all particulars of such action(s).**
- 15. Have you ever had a professional license suspended or revoked? Yes No **If yes, attach a detailed explanation that gives all particulars of such action(s).**
- 16. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Clinical Social Work Examiners? Yes No **If yes, attach a detailed explanation that gives all particulars of such action(s).**
- 17. Are you in violation of any grounds for disciplinary actions, as set forth in 24 *Del. C.*, 3915? Yes No **If yes, attach an explanation in full detail by giving all particulars of such action(s).**
- 18. Have you ever been denied licensure in any other jurisdiction? Yes No **If yes, attach a detailed explanation that gives all particulars of such action(s).**

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I certify that the information provided in this application is accurate and complete to the best of my knowledge and belief. I understand that the Delaware Board of Clinical Social Work Examiners has the right to deny or revoke licensure, if my application contains fraudulent information.

APPLICANT SIGNATURE: _____ DATE: _____

_____ (County)

_____ (State)

Before me personally appeared, _____, applicant, of lawful age, to me known to be the identical person who signed this document of application and being by me first duly sworn, on oath state that all the foregoing statements are true and correct to the best of _____ knowledge and belief.

Signature of Notary Public

Printed or Typed Notary Public's Name

My Commission expires: _____

(Seal)



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SUPERVISORY REFERENCE FORM

This form is to be completed by the supervisor of the person applying for a Delaware Clinical Social Worker license. The form's purpose is to document that the applicant has acquired two years of post-MSW degree clinical social work experience consisting of at least 3,200 hours, of which 1,600 hours were under the supervision of a licensed clinical social worker (LCSW), master of social work (MSW), licensed psychologist, or a licensed psychiatrist (24 Del. C. § 3907). During the period supervised, *at least one hour per week must be one-on-one face-to-face supervision* (Section 4.2 of the Board's Rules and Regulations). Additional forms are available on www.delaware.gov.

1. Applicant Name: _____
2. Supervisor Name: _____
3. Enter this information about your agency (if applicable):

Agency Name	
Address	
Phone	

4. Enter the following information about your education during the period you supervised this applicant:

University	Degree	Field	Date Conferred

5. Enter the following information about your license during the period you supervised this applicant:

License Number	Type of License	Date Issued

6. **Total** Clinical Supervised Hours: _____
7. **Total** Hours of One-To-One Supervision: _____

8. Dates of Post Master's Supervised Clinical Social Work Experience: From _____ To _____
Month/Year Month/Year

9. Use of professional values and ethics, professional knowledge, professional identity and use of self and disciplined approach to the practice environment should be reflected in each of the practice skills listed below.

I attest that the applicant has demonstrated satisfactory completion of the following practice skills during the 1600 hours of post-MSW degree professionally supervised clinical social work experience.	Answer each item.
Provides adequate clinical diagnoses and biopsychosocial assessments	Yes <input type="checkbox"/> No <input type="checkbox"/>
Performs short-term and/or long-term interventions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Establishes treatment plans with measurable goals	Yes <input type="checkbox"/> No <input type="checkbox"/>
Adapts interventions to maximize client responsiveness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recognizes when personal issues affect clinical objectivity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recognizes and operates within own practice limitations	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seeks consultation when needed	Yes <input type="checkbox"/> No <input type="checkbox"/>
Refers to sources of help when appropriate	Yes <input type="checkbox"/> No <input type="checkbox"/>
Practices within established ethical and legal parameters	Yes <input type="checkbox"/> No <input type="checkbox"/>

I attest that the applicant named above worked under my clinical supervision. I certify that I personally completed all sections of this form and the information provided herein is accurate and complete to the best of my knowledge and belief.

Signature of Supervisor: _____ **Date:** _____

Mail completed form directly to the Board office at the address above.



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VERIFICATION OF LICENSURE FORM

Section I – To be completed by applicant. Send form to states where you are current, or have ever been, licensed. You may duplicate this form.

Name	
License Type	
License #	
Phone #	

I hereby authorize _____ to release information regarding my licensure,
Name of state licensing Board/Authority
certification, or registration to the Delaware Board of Clinical Social Work Examiners.

Signature of Applicant: _____ **Date:** _____

Section II - To be completed by State Licensure Board/Authority. Mail completed form *directly* to the Delaware Board at address above.

Date of Original Registration/Licensure: _____

Registration/License No: _____ Expiration Date: _____

Type of Examination: ASWB Clinical Other Specify: _____

Pass/Fail Status as Determined by ASWB: _____ Date of Examination: _____

Has the licensee ever been subject to any disciplinary action, or had his/her license suspended or revoked?
Yes No ***If yes, enclose a certified copy of the board's final order.***

Are there any current or pending disciplinary proceedings or unresolved complaints against the applicant? Yes No

I certify the statements contained herein are true and correct.

Name of Official: _____ Title: _____

Name of Licensure Authority: _____

Address: _____

_____ Phone: _____

AFFIX BOARD SEAL

Signature of Official: _____ **Date:** _____