



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

### Selecting Type of Application

Apply by *examination* if you:

- are requesting approval to take the national Association of Social Work Boards (ASWB) licensing examination, **or**
- have already passed the ASWB licensing examination *but* you do **not** hold a **current, clinical** social work license in another jurisdiction (state, U.S. territory or District of Columbia).

Apply by *reciprocity* if you:

- have already passed the national ASWB licensing examination, **and**
- hold a **current, clinical** social work license in another jurisdiction (state, U.S. territory or District of Columbia).

### Requirements for All Applicants

- Submit completed, signed and notarized [application](#) form.
  - The application must clearly show the number of your **post-MSW degree clinical social work** hours.
  - Your clinical experience must consist of at least 3200 hours.
- Enclose the non-refundable [processing fee](#) by check or money order payable to the "State of Delaware."
- Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
  - You must meet this requirement *even if* you recently had a criminal background check done for some other reason.
- Arrange for your supervisor to complete and sign the *Supervisory Reference Form* included with the application. Your supervisor must send it *directly* to the Board office.
  - The form must document at least 1600 hours 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 have ever held a social work license in another jurisdiction (state, U.S. territory or D.C.), arrange for the Board office to receive verification of licensure from *each* jurisdiction where you have held a license, sent *directly* from the jurisdiction to the Board office.
- 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](http://www.cswe.org)).
- If you have already passed the ASWB exam, arrange for the Board office to receive a certified score report, sent directly from ASWB to the Board office. To request the score report, see [Score Transfer](#) on the ASWB web site.
- If you have *not* passed the ASWB examination, the Board office will notify you when you are approved to take the exam. To register online with ASWB, see [ASWB Registration Information](#).
  - For information about the examination, the [Candidate Handbook](#) is available on the ASWB web site. The Board office does not provide Candidate Handbooks.
  - 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.

- If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
- The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.



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### APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER

#### TYPE OF APPLICATION

1. Select the type of application you are filing:

Examination (check one):

I am requesting approval to take the ASWB clinical examination.

I have passed the ASWB clinical examination *but* I do **not** hold a current **clinical license** in another jurisdiction. (Check this one if you don't hold any current license **or** if you hold a license but it is not a **clinical** license.)

Reciprocity – I hold a **current, clinical license** in the jurisdiction of \_\_\_\_\_.

#### IDENTIFYING AND CONTACT INFORMATION

2. Name (no titles, credentials, etc.): \_\_\_\_\_  
Last/Family First Middle

3. Other Name(s) Used: \_\_\_\_\_

4. Date of Birth (month/day/year): \_\_\_\_\_ Gender: Male  Female

5. 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](#).

6. Mailing Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip

7. Phone: \_\_\_\_\_ Home Work Email: \_\_\_\_\_

#### EDUCATION & EXAMINATION

8. 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.**

9. Have you passed the ASWB clinical examination? Yes  No  **If yes, request ASWB to send a certified statement of your passing score on the examination to the Board office.**

**LICENSURE HISTORY & PROFESSIONAL EXPERIENCE**

10. Have you ever held a license in any other jurisdiction (state, U.S. territory or District of Columbia)? Yes  No   
 If yes, enter the following about *each* license:

JURISDICTION	LICENSE NUMBER	ISSUE DATE	STATUS (e.g., active)

**Arrange for the Board office to receive verification of licensure *directly* from *each* jurisdiction in which you have ever been licensed.**

11. List your professional clinical social work experience ***after your Master's degree was conferred***. Start with your 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 you need more room, enclose additional sheets with same information. ***Do not submit resumes.***

From \_\_\_\_\_ To \_\_\_\_\_ Total Number of Hours: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Supervisor's Name: \_\_\_\_\_  
 Supervisor Title/Professional Status: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Your Position/Title: \_\_\_\_\_  
 Job Responsibilities and Activities (continue on separate sheet, if needed: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_ Total Number of Hours: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Supervisor's Name: \_\_\_\_\_  
 Supervisor Title/Professional Status: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Your Position/Title: \_\_\_\_\_  
 Job Responsibilities and Activities (continue on separate sheet, if needed: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_ Total Number of Hours: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Supervisor's Name: \_\_\_\_\_  
 Supervisor Title/Professional Status: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Your Position/Title: \_\_\_\_\_  
 Job Responsibilities and Activities (continue on separate sheet, if needed: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. List present or former clinical supervisors who can verify your required post-Master's degree experience.

NAME	ADDRESS	PHONE	LICENSE #

Arrange for each supervisor listed to complete and sign the *Supervisory Reference Form* included with the application. Your supervisors must send the *directly* to the Board.

**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

Arrange for the Board office to receive state and federal criminal background checks.

14. Are criminal charges pending against you in any jurisdiction? Yes  No  **If yes, enclose a detailed explanation giving all particulars. Also, enclose any relevant documents.**

15. Are there now, or have there ever been, any pending professional disciplinary actions against you? Yes  No  **If yes, enclose a detailed explanation giving all particulars.**

16. Have you ever been denied licensure in any other jurisdiction? Yes  No  **If yes, enclose a detailed explanation giving all particulars.**

17. Have you ever had a professional license suspended or revoked? Yes  No  **If yes, enclose a detailed explanation that gives all particulars.**

18. Are you presently in violation of any [Rule and Regulation](#) of the Delaware Board of Clinical Social Work Examiners? Yes  No  **If yes, enclose a detailed explanation giving all particulars.**

19. Are you in violation of any grounds for disciplinary actions listed in [24 Del. C., 3915](#)? Yes  No  **If yes, enclose a detailed explanation giving all particulars.**

**DUTY TO REPORT**

20. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that **any healthcare provider** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Clinical Social Work Examiners

- has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
- may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

I certify that I have read and understand [24 Del. C. §3919](#), [24 Del. C. §1730](#), [24 Del. C. §1731](#) and [24 Del. C. §1731A](#) and that I understand my *duty to report* to the Division of Professional Regulation. Yes  No

21. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes  No

22. You have a **mandatory** duty to report your knowledge of a colleague's impairment, incompetence or unethical conduct to the Board of Clinical Social Work Examiners when the colleague has not addressed the problem or when a client's welfare appears to be in danger.

I certify that I have read and understand Section 9.3.5 of the [Rules and Regulations](#) and understand my *duty to report*. Yes  No

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 months of filing may be considered abandoned and discarded.

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.

**Signature of Applicant:** \_\_\_\_\_ Date: \_\_\_\_\_

City of \_\_\_\_\_ County of \_\_\_\_\_

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 his or her knowledge and belief.

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_.

Signature of Notary: \_\_\_\_\_

SEAL

My commission expires: \_\_\_\_\_

**APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.**



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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 at least 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](http://www.delaware.gov).

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

<b>Agency Name</b>	
<b>Address</b>	
<b>Phone</b>	

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

<b>University</b>	<b>Degree</b>	<b>Field</b>	<b>Date Conferred</b>

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

License Number: \_\_\_\_\_ License Type: \_\_\_\_\_ Issue Date: \_\_\_\_\_

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.

<b>I attest that the applicant satisfactorily demonstrated the following practice skills during the 1600 hours of post-MSW degree professionally supervised clinical social work experience.</b>	<b>Answer each item.</b>
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 jurisdictions where you are currently, or have ever been, licensed. You may copy this form.**

<b>Name</b>	
<b>License Type</b>	
<b>License #</b>	
<b>Phone #</b>	

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.

**Applicant Signature:** \_\_\_\_\_ **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:** \_\_\_\_\_

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

# Instructions for Requesting a Criminal Background Check

*Both state and federal criminal background checks are required.*

## Locations

### Kent County – Primary Facility

State Bureau of Identification  
Blue Hen Mall & Corporate Center  
655 Bay Rd. Suite 1B  
Dover, DE 19901

**Walk-ins accepted:** Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm  
Customer Service: (302) 739-2134

### New Castle County - Satellite Facility

State Police Troop Two  
100 LaGrange Ave  
Newark, DE 19702  
(Between Rts. 72 and 896 on Rt. 40)  
**By appointment only**  
Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

### Sussex County – Satellite Facility

Delaware State Police Troop Four  
South DuPont Hwy & Shortley Rd. Georgetown DE  
19947  
(Across from DelDOT & the State Service Ctr.)  
**By appointment only**  
Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

## Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$69.00, to cover both the State and Federal criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

## Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.
2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned. Send the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for \$69.00 made payable to “Delaware State Police” to:

**Delaware State Police  
State Bureau of Identification (SBI)  
PO Box 430  
Dover, DE 19903-0430**

⇒ **ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.**

**DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE**



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## CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

### AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

#### CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Adult Entertainment   | <input type="checkbox"/> Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT) | <input type="checkbox"/> Psychology               |
| <input type="checkbox"/> Deadly Weapons Dealer   | <input type="checkbox"/> Nursing (RN, LPN, APN)                           | <input type="checkbox"/> Social Work              |
| <input type="checkbox"/> Dental  | <input type="checkbox"/> Nursing Home Administrator                       | <input type="checkbox"/> Texas Hold'em Individual |
| <input type="checkbox"/> Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors) | <input type="checkbox"/> Pharmacy   |   |

#### ENTER FULL CURRENT NAME:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

#### ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

**SIGNATURE OF PERSON PRINTED:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

#### MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO:

**Division of Professional Regulation**  
**861 Silver Lake Boulevard, Suite 203**  
**Dover DE 19904**  
**SLC D420A**

**USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.**