DEPARTMENT OF HEALTH

APPLICATION FOR

CERTIFIED MASTER SOCIAL WORKER

http://floridasmentalhealthprofessions.gov

Rule 64B25-28.012
DH-CMS 2061 (Revised 07/16)

MAKE COPIES OF ALL DOCUMENTS

(for your records) prior to mailing the originals to the Department.

MAIL APPLICATION AND FEE TO:

(Make checks payable to the Department of Health and securely attach to the application.)

CERTIFIED MASTER SOCIAL WORKER
PO BOX 6330
Tallahassee, FL 32314-6330

Mail ALL OTHER CORRESPONDENCE TO:

(Transcripts, Licensure Verification forms, Supervised Experience forms or anything without a fee)

CERTIFIED MASTER SOCIAL WORKER
4052 Bald Cypress Way, BIN #C08
Tallahassee, FL 32399-3258

Information mailed from a source other than the applicant, must have the applicant's full name on the correspondence or documentation. If you have further questions, you may contact the application reviewers at (850) 245-4474 between the hours of 8:00 AM and 5:00 PM EST.

APPLICATION CHECKLIST

The following items must be received in order for your application to be considered complete:

√ Mailed by the Applicant:

- ☐ Completed and Signed Application
- ☐ Required Fees
- ☐ Experience Form(s)

√ Mailed by the Originating Source:

- ☐ Official Transcript
- ☐ Supervised Experience forms - If Applicable
- ☐ Licensure Or Certification Verification Forms - If Applicable
- ☐ Examination Scores - If Applicable

YOUR PRACTICE LOCATION ADDRESS WILL SHOW ON THE INTERNET LICENSE VERIFICATION

Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The “mailing address” is used whenever documents, renewal information, etc. are mailed to the applicant/licensee. Our Internet License Verification provides the public with information on licensed health care practitioners in the state of Florida, including an “address of record”. The “practice location address” from the licensure database will show as the “address of record” on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

APPLICATION FOR CERTIFIED MASTER SOCIAL WORKER INSTRUCTIONS

You must read the Laws and Rules in order to determine your eligibility prior to applying. See section 491.0145 Florida Statutes, and the Rules in 64B25-28, Florida Administrative Code. The statutes may be accessed at www.leg.state.fl.us and the rules may be accessed at www.flrules.org.

LICENSURE REQUIREMENTS:

- A master's degree in social work with specific coursework
- Three (3) years experience in clinical services or administrative activities, two (2) years of which must be at the post-master's level under the supervision of a certified master social worker or licensed clinical social worker
- Pass the National ASWB Advanced Generalist Examination

I. EXAMINATION INFORMATION

To become eligible to sit for the ASWB (Association of Social Work Boards) Advanced Generalist Examination, you must first submit the application for certified master social worker and fees with supporting documentation for Department review. The Department sends approved candidates an exam approval letter with appropriate registration materials. If you have already passed the Masters Level Examination, you may transfer your scores to Florida for review. These scores must be received from the testing center or directly from the State in which you took the **ASWB Advanced Generalist Examination.**

The national examination is offered weekly, Mon.-Sat. by individual appointment in a computer-based format Worldwide. There are no completion deadlines. Approved candidates schedule and pay for the national examination directly through ASWB. The exam may be re-taken every 90 days. A study prep guide may be purchased from the ASWB at 1-800-225-6880, by mail request to: ASWB, 400 South Ridge Parkway, Suite B, Culpepper, Virginia 22701 or online at www.aswb.org. Remember that you must request the Advanced Generalist Examination Study Guide.

SPECIAL TESTING ACCOMMODATIONS

If you need special accommodations, you will need to contact the Association of Social Work Boards (ASWB) directly. Their contact information is 1-800-225-6880 or www.aswb.org.

II. FEES

Make your cashier's check or money order payable to the Department of Health and securely attach to the application. The required fees total $205.00, as shown below.

Application Fee:	$ 50.00
Initial Certification Fee	150.00
Unlicensed Activity Fee:	5.00
TOTAL:	$205.00

III. OFFICIAL TRANSCRIPTS

You must request an official transcript from the accredited institution from which you received your degree. This transcript must be sent directly to the Department of Health from the registrar's office of the institution or they will not be considered official.

FOREIGN EDUCATION

For the Department to consider education completed outside the U.S. or Canada, documentation must be received which verifies the institution at which the education was completed was equivalent to an accredited U.S. institution and the coursework met the content and credit hour requirement for graduate level coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized educational evaluation service that documents the acceptability of the coursework.

DOCUMENTS IN A FOREIGN LANGUAGE
A certified translator who is not related to the applicant must translate any document in a foreign language into English.

IV. COMPLETING THE FORMS
Complete all forms by printing neatly in ballpoint pen or typing the information on the forms.

APPLICATION FOR CERTIFIED MASTER SOCIAL WORKER [6 pages]
It is your responsibility to notify this office in writing if the answer to any application question changes, even if the application is already approved or you have already taken the exam.

1. Applicant Profile Data
List your legal name as it should appear on your license. Your mailing address is used whenever you are sent documents, renewals, licenses, etc. from the Department of Health. When you become a licensee, your name, license number and practice location address will be shown on our Internet License Verification. If you do not want your mailing address on the website, fill in the "practice location address" on the application as you want it to appear on the website. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

2. Applicant Certification Status
List all counseling related professional licenses, including inactive or expired licenses issued from any state, U.S. territory, or foreign country.

3. Professional Experience
Your supervised experience should be listed beginning with your current employment. This section will be compared to the forms submitted to verify experience. Do not attach a resume. Do not list experience that is not in the field. If you had more than one supervisor during the same time period, you must attach a brief explanation.

4. Education
List the degree(s) you hold, beginning at the master's level. Identify your program of study at the college or university where you received this degree. Include the month and year in which the degree was received.

5. Applicant History – Professional
If you answer "yes" to any question in this section, you must provide complete details. A "yes" answer does not mean the application will be denied, however, failure to provide the correct information may result in licensure denial.

6. Applicant History – Pursuant to Section 456.0635, Florida Statutes
Important Notice: Applicants and candidates for examination may be excluded from licensure, certification or registration if their felony conviction or plea falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.

7. Applicant History – General
If you answer "yes", you must provide complete details and copies of court records/dispositions.

8. Certification
Read this section carefully. Your signature is required. By signing this statement you are confirming you have provided true and correct information on the application and supporting documents, as well as having read the laws and rules.

9. Social Security Number
You must provide an accurate social security number to become licensed. This information is not public record and will not be disclosed.

10. Applicant History - Health

The Department reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and safety. If you answer "yes" to any of the questions in this section, you must submit a current mental health status report from a licensed mental health professional with which you have no personal or professional relationship.

The report should include: a description and summary of the diagnosis, onset, course of treatment, medications, inpatient treatments, outpatient treatments, group settings, factors which have triggered setbacks, compliance with treatment, prognosis, and recommendations for continued treatment.

LICENSURE OR CERTIFICATION VERIFICATION FORM

This form is only to be completed if you hold or have held a license or certification in another state, U.S. territory, or foreign country. You must mail this form to the office that issued the license or certification. That office must complete and mail the form directly to the Department. It will not be considered official if received from the applicant.

EXPERIENCE FORMS

The application package includes the **Pre-Master's Experience Form** and the **Post-Master's Supervised Experience Form.** If additional forms are needed please make photocopies. Three (3) years of experience are required. All pre-master's experience must be documented on a Pre-Master's Experience Form. Post master's supervised experience may be verified by completing a Supervised Experience Attestation Form or documenting one of the following:

- MEMBER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW)
- MEMBER OF THE NATIONAL REGISTER OF HEALTH CARE PROVIDERS IN CLINICAL SOCIAL WORK
- MEMBER OF THE ACADEMY OF CERTIFIED SOCIAL WORKERS (ACSW)
- BOARD CERTIFIED DIPLOMATE BY THE AMERICAN BOARD OF EXAMINERS IN CLINICAL SOCIAL WORK
- BOARD CERTIFIED DIPLOMATE BY THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

1. Pre-Master's Experience Form

Only one (1) year of pre-masters experience can be counted towards the required three (3) years experience.

2. Supervised Experience Form - Post Master's

You are required to complete two (2) years of post-master's supervised experience. It is your responsibility to provide each supervisor with a copy of Section 491.0145, F.S., and the appropriate Department rules on the qualification of a supervisor.

Please refer to Rule Chapter 64B25-28 for rules on supervised experience, specifically:

- 64B25-28.013(1), (2) Definition of Experience
- 64B25-28.012(2) Application Requirements
- 64B25-28.012(2)(e) Qualified Supervisors
- 64B25-28.013(4), (6) Definition of Supervision
- 64B25-28.013(5) Supervision Requirements
- 64B25-28.013(7) Verification of Supervised Experience

APPLICATION FOR CERTIFIED MASTER SOCIAL WORKER (5401)

1. APPLICANT PROFILE DATA *(PLEASE TYPE OR PRINT IN BLACK INK)*

Name	Last	First	Middle
Mailing Address	Street and No.		Apt. No.
	City	State	Zip
*Practice Location Address	Street and No.		Apt. No.
	City	State	Zip

NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?

❑ YES ❑ NO If "YES" list name(s) below:

Home Telephone: area code ( )	Business Telephone: area code ( )
E-mail Address: (Optional. Will be public record if provided.)	Date of birth: _____/_____/_____

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: Sex:

❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian ❑ Native American ❑ Other _____ ❑ Male ❑ Female

EDUCATION DATA

Name of School, College or University	Degree	Date of Graduation

EXAMINATION DATA

Have you passed the National ASWB Masters Level Examination? ❑ YES ❑ NO

SPECIAL TESTING ACCOMMODATIONS: See Application Instructions

* Your Practice Location Address Will Show on the Internet License Verification

Our Internet License Verification provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet.

Print clearly or type the following information.

APPLICANT NAME _____

2. APPLICANT CERTIFICATION STATUS

A. Do you hold or have you ever held a license or certificate to practice any counseling-related professions in any state, U.S. territory, or foreign country? ❑ YES ❑ NO

If YES, list <u>all</u> licenses and the issuing state, territory, or foreign country:

B. Do you have any applications for licensure in a counseling-related profession currently pending in any state (including Florida), U.S. territory, or foreign country? ❑ YES ❑ NO

If YES, list <u>all</u> pending applications and the issuing state, territory, or foreign country:

3. PROFESSIONAL EXPERIENCE

Starting with your most recent supervised experience, list below all supervised experience for which your supervisor will provide documentation. Attach additional sheets if necessary.

Dates of Experience	Place of Employment	Hours Worked Per Week	Name of Supervisor
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____
4. _____	4. _____	4. _____	4. _____
5. _____	5. _____	5. _____	5. _____
6. _____	6. _____	6. _____	6. _____
7. _____	7. _____	7. _____	7. _____

APPLICANT NAME _____

4. EDUCATION

List all schools used on your Education Worksheet.

Degree	Major	School	Date of Graduation
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____

5. APPLICANT HISTORY - PROFESSIONAL

A.	Have you ever been denied a psychotherapy or counseling-related license or the renewal thereof in any state?	❑ YES ❑ NO
B.	Have you ever been denied the right to take a psychotherapy or counseling-related licensure examination?	❑ YES ❑ NO
C.	Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	❑ YES ❑ NO
D.	Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in a psychotherapy or counseling-related profession?	❑ YES ❑ NO
E.	Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including: 1. Acts of dishonesty, fraud, or deceit 2. Lying on a resume or misrepresentation 3. Academic misconduct, including acts such as cheating or plagiarism 4. Theft 5. Sexual harassment	1.❑ YES ❑ NO 2.❑ YES ❑ NO 3.❑ YES ❑ NO 4.❑ YES ❑ NO 5.❑ YES ❑ NO

If you answered "YES" to any question in Section 5, you must provide the Department complete details.

APPLICANT NAME _____

6. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,
IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation. Supporting documentation includes court dispositions or agency orders where applicable.

1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to # 2.)	❑YES ❑NO
a.	If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?	❑YES ❑NO
b.	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	❑YES ❑NO
c.	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	❑YES ❑NO
d.	If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	❑YES ❑NO
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	❑YES ❑NO
a.	If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	❑YES ❑NO
3.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	❑YES ❑NO
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	❑YES ❑NO
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	❑YES ❑NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑YES ❑NO
b.	Did the termination occur at least 20 years before the date of this application?	❑YES ❑NO
5.	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	❑YES ❑NO

APPLICANT NAME _____

7. APPLICANT HISTORY - GENERAL

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any crime in any jurisdiction, other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

❑ YES ❑ NO

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a copy of the court records/dispositions.

8. CERTIFICATION

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Department's decision concerning my eligibility for examination or licensure. Such supplement is required by Chapter 456.072, F.S. and 456.013(1)(2), F.S. Failure to do so may result in disciplinary action by the Department including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying.

I confirm that I will comply with all requirements for license renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits.

I hereby acknowledge receipt of Chapter 491, F.S., and related rules and further that I have read these regulations. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 491, F.S., and related rules. I understand that pursuant to Chapter 456.013(1)(a), F.S., an incomplete application shall expire 1 year after initial filing.

_____ _____

Applicant's Signature Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH

Certified Master Social Worker

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 USCA § 666 (a)(13); and Sections 456.013, 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

Name: _____
Last **First** **Middle**

9. Social Security Number: _____

10. APPLICANT HISTORY – HEALTH **If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.**	
A. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B. In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C. During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D. In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E. During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F. During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

EDUCATION WORKSHEET
CERTIFIED MASTER SOCIAL WORKER

PRINT CLEARLY OR TYPE THE FOLLOWING INFORMATION:

APPLICANT NAME:_____

You are required to have a master's or doctoral degree in social work with a major emphasis or specialty in clinical practice or administration and complete graduate level coursework in the following areas: agency administration and supervision, program planning and evaluation, staff development, research, community organization, community services, social planning and human service advocacy. You must indicate below the graduate or doctorate level course you completed that satisfied the education requirement in the specific content area.

CONTENT AREA	SCHOOL	COURSE NUMBER	COURSE TITLE
Agency Administration and Supervision			
Program Planning and Evaluation			
Staff Development			
Research			
Community Organization			
Community Services			
Social Planning			
Human Services Advocacy			

CERTIFICATION/LICENSE VERIFICATION

CERTIFIED MASTER SOCIAL WORKER

Print clearly or type the following information.

APPLICANT NAME _____

Applicant's Address:	
Title of License:	License Number:

THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO:

CERTIFIED MASTER SOCIAL WORKER
4052 BALD CYPRESS WAY, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.

Title of License:	License Number:
Original Issue Date:	Expiration Date:
License Status: ❑ Active ❑ Inactive ❑ Temporary ❑ Other (Explain)	
Licensure Method: ❑ Examination	
Complete the following: **Name of Exam:**	
Level of Exam: **Date of Exam:**	**Score Achieved:**

Has any disciplinary action been taken against this license? ❑ YES ❑ NO
If "YES", please provide our office with any documentation regarding the disciplinary action.

Do you have any information relating to criminal conviction or disciplinary action concerning this person? ❑ YES ❑ NO
If "YES", please explain:

Affix Board Seal	Signature:
	Title:
	Date:
	Phone Number:
	Board of:
	State of:

Rule 64B25-28.012
DH-CMS 2061 (Revised 07/16)

Certified Master Social Worker
PRE-MASTER'S EXPERIENCE FORM

Print clearly or type the following information.

APPLICANT'S NAME:_____

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE PERSON VERIFYING THE EXPERIENCE

Name: Phone:

Address:

Office or Agency where this experience took place:

Relationship to Applicant: (check one)

❑ Employer ❑ Co-Worker ❑ Supervisor ❑ Personnel Representative

HOURS WORKED BY THE APPLICANT

A. Dates of the Applicant's experience:

From: _____ To: _____
month/day/year month/day/year

B.

_____	X	_____	=	_____
number of **WEEKS** worked by the applicant		average number of hours worked per **WEEK** by the applicant		total number of hours worked by the applicant

C.

_____ Average number of hours per **WEEK** the applicant provided psychotherapy face-to-face directly to clients.

_____ Average number of hours per **WEEK** the applicant spent working in administration or supervision related to social work programs.

CERTIFICATION

I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Signature Date

4052 Bald Cypress Way, BIN #C08
Tallahassee, FL 32399-3258
(850) 245-4474

CERTIFIED MASTER SOCIAL WORKER
POST-MASTER'S SUPERVISED EXPERIENCE FORM

Print clearly or type the following information

APPLICANT'S NAME _____

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE PERSON VERIFYING THE EXPERIENCE

Name: Phone:

Address:

I. EDUCATION *(To Be Completed By Supervisor)*

Graduate Degree	Degree Title	College/University
1.	1.	1.
2.	2.	2.

II. LICENSURE/CERTIFICATION/CREDENTIAL *(To Be Completed By Supervisor)*

Are you licensed, certified, or credentialed? ❑ Yes ❑ No

If No, you must attach 1) a photocopy of your graduate level transcript and; 2) a professional resume.

If Yes, complete the following.

License Title	State	Year Received	License Number
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.

Certification/ Credential Title (attach photocopy)	Organization/ State	Year Received	Certification/ Credential Number
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.

If you are credentialed or certified by a national organization, attach a photocopy of your certificate.

APPLICANT'S NAME _____

III. HOURS WORKED BY APPLICANT/HOURS OF SUPERVISION *(To Be Completed By Supervisor)*

A. Dates of the Applicant's Supervised Experience:

From: _____ To: _____
month/day/year month/day/year

B. _____ X _____ = _____

number of **WEEKS** worked by the applicant	average number of hours worked per **WEEK** by the applicant	total number of hours worked by the applicant

C. _____ Average number of hours per **WEEK** the applicant provided psychotherapy face-to-face directly to clients.

_____ Average number of hours per **WEEK** the applicant spent working in administration or supervision related to social work programs.

D. _____ + _____ = _____

number of hours per **MONTH** you provided the applicant individual face-to-face supervision	number of hours per **MONTH** you provided the applicant group supervision	total hours per **MONTH** you provided the applicant supervision

IV. CERTIFICATION BY SUPERVISOR *(To Be Completed By Supervisor)*

I confirm that I have read and understand Chapter 491, Florida Statutes and that I am qualified to supervise as specified in the appropriate rules. I further attest, that supervision included: a focus on raw data from the supervisee's clinical work, which was made directly available through such means as written clinical materials, direct observation, and video and audio recordings; face-to-face contact between the applicant and myself during which the applicant apprised me of the diagnosis and treatment of each client; discussion of the clients' cases; oversight and guidance in diagnosing, treating, and dealing with clients; and evaluation of the applicant's performance.

I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Supervisor's Signature Date

CERTIFIED MASTER SOCIAL WORKER
4052 Bald Cypress Way, BIN #C08
Tallahassee, Florida 32399-3258
(850) 245-4474