STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF SUPERVISION

Applicant's Name _____ Phone _____
Mailing Address _____
Agency/Organization Employed by _____
Name of Supervisor _____ Title _____
Dates Employed: from _____ to _____

TO BE COMPLETED BY SUPERVISOR

Name and Title: _____

Agency/Organization employed by during supervision of above applicant: _____

Title/position held at time of supervision of above applicant: _____

At the time such supervision was provided, please list the states in which you were licensed/certified as a Clinical Social Worker. _____ License/Certificate No: _____ Initial licensure/certification date: _____

Dates supervision was provided: from _____ to _____

NOTE: ***Professional supervision*** *means face-to-face consultation between one supervisor and one supervisee consisting of review, periodic written evaluation, and assessment of the supervisee's practice of* ***clinical social work****.*

For purposes herein, ***clinical social work*** *means the application by persons trained in social work of established principles of psychosocial development, behavior, psychopathology, unconscious motivation, interpersonal relationships and environmental stress to the evaluation, assessment, diagnosis and treatment of biopsychosocial dysfunction, disability and impairment, including mental, emotional, behavioral, developmental and addictive disorders of individuals, couples, families or groups. Clinical social work includes, but is not limited to, counseling, psychotherapy, behavior modification and mental health consultation.*

Nature of clinical work performed by applicant (attach additional sheet if necessary) _____
_____
_____

Total number of hours of ***professional supervision*** provided to the above applicant: _____

Do you have any derogatory information regarding the competency or conduct of this individual? Yes ☐ No ☐
If yes, please explain (attach additional sheet if necessary): _____
_____

_____

I certify that written evaluation reports have been maintained during the course of my supervision. I also understand that these reports are subject to review upon request by the Department of Public Health. All of the statements contained herein are true and correct to the best of my knowledge and belief.

_____ _____
Signature Date

_____
Name of Agency Address City State Zip Code

Telephone Number _____

This completed form must be returned by the supervisor directly to:

Department of Public Health • Clinical Social Work Licensure • 410 Capitol Ave., **MS #12APP** • P.O. Box 340308 • Hartford, CT 06134-0308 • (860) 509-8386