NORTH CAROLINA SOCIAL WORK
CERTIFICATION AND LICENSURE BOARD

P.O. Box 1043
Asheboro, NC 27204
Ph: 336-625-1679

Website: www.ncswboard.org

Review Period: __/__/____ to: __/__/___
mm/dd/yyyy mm/dd/yyyy

LCSWA SIX-MONTH REVIEW

All LCSWA licensees are required to receive supervision of their clinical social work practice during their associate status. Appropriate supervision, unless otherwise pre-approved by the Board (in writing), ***shall*** be provided by a North Carolina licensed LCSW in good standing with the Board, who has a MSW degree, and at least two years of post LCSW clinical practice experience. Supervision and practice shall be reported to the Board every six months pursuant to NC Administrative Code [21 NCAC 63 .0210].

SECTION I: To be completed by the LCSWA licensee

Name (Print): _____ LCSWA # _____

Address: _____ City, State, Zip _____

Place of Employment (for this review period): _____

Employment Verification with job description (check one): Is attached □ ***OR*** has already been submitted □

LCSWA Daytime Phone: _____

LCSWA Signature: _____ Date: _____
mm/dd/yyyy

SECTION II: LCSW clinical supervisor shall acknowledge by checkmark (√) or initials that each bulleted item has been completed.

- _____ Position Statement has been signed and submitted to the Board.
- _____ Emergency Crisis Plan has been submitted to the Board insuring immediate access to emergency consultation.
- _____ A supervisory log has been maintained and is available upon request to verify documented supervision.
- _____ Case narrative summarizing one case treated during this review period has been prepared, reviewed, and is on file and available for Board review if needed.

SECTION III: (Required) This section to be completed ONLY BY LCSW CLINICAL SUPERVISOR. You are encouraged to share your assessment with your supervisee as part of the supervision process.

Rate the LCSWA supervisee in all areas using the following key: *(Reference the Supervisor Manual for an explanation of key terms).* **Excellent (E) Very Good (VG) Good (G) Fair (F) Poor (P)**

1._____Ethical standards of social work practice
2._____Effective use of supervision
3._____Competence in social work practice
4._____Professional growth and development
5._____Consistency of performance effort
6._____Knowledge of social work principles and practices
7._____Ability to formulate a treatment plan appropriate to the clients' needs
8. _____Ability to implement interventions consistent with the treatment plan
9. _____Supervisee's ability to assess his/her own capacities and skills
10. _____Ability to correctly diagnose mental and emotional disorders
11. _____Ability to plan treatment & carry out clinical interventions related to mental & emotional disorders

SECTION IV: (Required) All portions of this section are to be completed ONLY BY LCSW CLINICAL SUPERVISOR.
Provide a narrative summary regarding the LCSWA licensee's growth as a clinical practitioner and participation in clinical supervision.

_____

_____

_____

_____

_____

Supervision period (mm/dd/yyyy): _____ to _____

Face to Face (In-person) Hours of Supervision provided (*this review period only*): GROUP_____INDIVIDUAL _____

Hours of Supervision provided through technology (*this review period only):* GROUP_____INDIVIDUAL_____

Clinical Practice Hours (*this review period only*): _____

I affirm that the supervisee has practiced clinical social work and has demonstrated skill through practice experience as defined by statute [NCGS 90B-3] and Code [21 NCAC 63 .0102]; and that the above hours of supervision have occurred with the LCSWA as indicated. I certify that I am a current LCSW with a graduate degree in social work from a CSWE accredited program and that I am in good standing with the Board.

LCSW Supervisor Signature_____ **Date signed** _____/_____/_____
MM DD YYYY

Print name_____ **LCSW #:** _____ **Expires**: ____/____/_____
MM DD YYYY

Daytime phone # _____

Please retain a copy of this document for your files. [In accordance with NCGS 90B-6(i), you are required to maintain records for a minimum of 3 years from the date services are terminated.] You will not receive a response from the Board unless there is a concern or additional action is needed. If you wish to confirm receipt, please mail to the Board by traceable service.

BELOW SPACE FOR BOARD USE ONLY

Approval is granted for appropriately supervised clinical practice pursuant to NCGS 90B, the Social Worker Certification and Licensure Act, and Title 21, Chapter 63 of the N.C. Administrative Code, defining clinical social work practice, ***and*** at the required 1:30 supervision ratio.

Reviewer's Initials: _____ Date of Review: _____/_____/_____ Follow up needed: _____
MM DD YYYY Yes / No