NORTH CAROLINA
SOCIAL WORK CERTIFICATION AND LICENSURE BOARD
Post Office Box 1043
Asheboro, North Carolina 27204
Phone (336) 625-1679
Fax (336) 625-4246
Website: www.ncswboard.org

EMPLOYMENT VERIFICATION

For LCSWA or new Applicant with supervised clinical practice out of state

ONLY COMPLETE THIS FORM IF YOU ARE CURRENTLY LICENSED AS A LCSWA OR ARE A NEW APPLICANT DOCUMENTING SUPERVISED CLINICAL PRACTICE ACCRUED OUT OF STATE

INSTRUCTIONS TO COMPLETE THIS FORM

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK

1. A ***separate form must be completed for each place of employment***. This form may be duplicated.
2. ***ATTACH a job description*** on company letterhead to this form, which corresponds to each position being documented.
3. Complete section I. Then submit the ***entire form*** to your employer for completion of Section II & signature.

SECTION I: LCSWA LICENSEE OR APPLICANT INFORMATION

(To be completed by the LCSWA or Applicant)

Pursuant to the Social Worker Certification and Licensure Act [NCGS § 90B-15] your license shall be conspicuously displayed at your primary place of practice. Please verify your issue date and expiration date below.

LAST NAME:	FIRST NAME:	MIDDLE NAME:
LICENSE # AND STATE:	ISSUE DATE:	EXPIRATION DATE:
MAILING ADDRESS: (NEW ADDRESS ☐)	EMAIL ADDRESS	DAYTIME PHONE:
CITY	STATE	ZIP CODE

SECTION II: TO BE COMPLETED BY THE EMPLOYER

AGENCY NAME - FOR POSITION REPORTED ON THIS FORM:

AGENCY ADDRESS:

City: State: Zip Code:

LICENSEE/APPLICANT'S POSITION TITLE:
(**job description MUST be attached for this Position**)

IN THIS POSITION, IS THE LICENSEE AUTHORIZED TO PROVIDE CLINICAL SERVICES? (**CIRCLE ONE**) **YES** **NO**

NAME OF LICENSEE/APPLICANT'S ***LCSW*** **CLINICAL** SUPERVISOR: SUPERVISOR LOCATED: (circle one)

LCSW #: ON SITE OFF SITE

Is/Was the social worker being paid a fee or salary? □ YES □ NO Identify type & beginning date of position below:

FULL-TIME	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)
PART-TIME	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)
PRN	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)

PRINT NAME & TITLE OF PERSON COMPLETING EMPLOYER SECTION: ____

SIGNATURE: DATE: