



**SECTION IV: (Required) All portions of this section are to be completed ONLY BY LCSW CLINICAL SUPERVISOR. LCSWA licensees may NOT complete this section of the form.** Provide a narrative summary regarding the LCSWA licensee's growth as a clinical practitioner and participation in clinical supervision.

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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 # \_\_\_\_\_

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**Please retain a copy of this document for your files. [In accordance with NCGS 90B-6(j), 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