FOR LISW APPLICANTS ONLY - REPORT OF SUPERVISED EXPERIENCE

TO BE COMPLETED BY SUPERVISOR AFTER LISW (CP or AP) SUPERVISION HAS TAKEN PLACE

APPLICANT'S NAME:_____

The following information is to be completed by the supervisor:

Name:_____ **Academic Degree:**_____

Address:_____ **Institution:**_____

_____ **Work Phone:**_____

Please list license numbers (not certifications or registrations) you hold in SC or any other state.

Number	Date Issued	State	Level	In Good Standing

List the setting in which supervised practice occurred

Name of Practice Setting:_____

Address:_____

Nature of Practice Setting: **Clinical:**_____ **Hospital:**_____ **Other:**_____

Please specify dates and hours of practice and supervision.

CHAPTER 40-63-240 (A)(6) STATES: 3000 hours of social work practice under clinical/advanced supervisor must be completed by the supervisee over a minimum of 2 years and maximum of 4 year period. The supervision must include face-to-face meetings between the approved clinical/advanced supervisor and the supervisee for a minimum of 100 hours equitably distributed.

Supervision began on:_____ **Supervision ended on:**_____

Total number of direct face-to-face supervision hours over this period:_____

Total number of clinical/advanced practice hours over this period:_____

PLEASE ANSWER THE QUESTIONS ON THE FOLLOWING PAGE AS ACCURATELY AS POSSIBLE.

1. **Description of supervision:** Please describe in detail the specific nature of supervision. Describe the supervisory methods and the nature of the issues dealt with in supervision.

2. **Assessment of performances:** Please provide a critical evaluation of the applicant's performance, noting strengths, weaknesses, etc.

3. **Recommendation for Independent Practice:** Please indicate whether or not you recommend this applicant for independent practice. Please note the particular areas of practice in which you feel the applicant is qualified.

All of the statements made in this report are true and accurate to the best of my knowledge.

Signature:_____ **Date:**_____

Send to: **SC Board of Social Work Examiners**
P O Box 11329
Columbia SC 29211-1329