South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Social Work Examiners
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P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4664 • Contact.SocialWork@llr.sc.gov • Fax: 803-896-4719
www.llr.sc.gov/POL/SocialWorkers/

FOR LISW APPLICANTS ONLY - REPORT OF SUPERVISED EXPERIENCE

Licensee: _____   License No.: _____

To be completed by supervisor after LISW (CP or AP) Supervision has taken place. Once completed, form should be signed and mailed directly to the Board at the address above.

SUPERVISOR INFORMATION

Supervisor Name: _____   Phone: _____

Business Address: _____

Education Institution: _____   Academic Degree: _____

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

Issuing State	License Type / Level	License Number	Date Issued	Status of License

SUPERVISED EXPERIENCE DETAILS

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.

List the setting in which supervised practice occurred:

Name of Practice: _____   Phone: _____

Physical Address: _____

Nature of Practice Setting: Clinical   Hospital   Other: _____

Attach a log that specify dates and hours of practice and supervision.

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 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:**_____