STATE COMMITTEE FOR SOCIAL WORKERS
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City, MO 65102-1335
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Fax: (573) 526-4220
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri
lcsw@pr.mo.gov
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Registration of Supervision / Change of Status
Effective August 8, 2018

Dear Sir/Madam,

Thank you for your inquiry into the process of licensure for clinical, baccalaureate, or advanced macro social work in Missouri. Attached you will find the following document.

1. **Registration of Supervision Application / Change of Status**

Registration of Supervision application are not considered complete until ALL of the following information has been received in the committee office:

1. **You must hold a current license as an LMSW (for clinical or advanced macro supervision) or an LBSW (for baccalaureate independent practice supervision)**
2. **Complete Registration of Supervision Application (original signatures required)**
3. **$25.00 Registration Fee, payable to the Division of Professional Registration (NO FEE REQUIRED FOR CHANGE OF STATUS)**
4. **Employment verification letter sent on employer's letterhead**
5. **Copy of supervisor's 16-hour supervision training course certificate of completion and/or current 3 hour supervision training.**

According to 20 CSR 2263-2.032, supervised social work experience shall be registered for approval by the committee **prior** to the beginning of supervision. This will ensure that the supervision is acceptable to the committee prior to applying for licensure.

The committee reminds you to read the rules and statutes regarding supervision. Should you have any questions, please contact the committee office 573.751-0885 or lcsw@pr.mo.gov.

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STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
REGISTRATION OF SUPERVISION/CHANGE OF STATUS

MISSOURI DIVISION OF PROFESSIONAL REGISTRATION
STATE COMMITTEE FOR SOCIAL WORKERS

INSTRUCTIONS: Read the Supervision Guidelines. The **ORIGINAL** of this form must be submitted to the Board within ***14-days*** from the beginning date of supervision or change of status, otherwise hours may not be allowed. Keep a copy for your records. After all necessary documents are received, the Board will send a letter of approval. Please retain a copy for your records.

SUPERVISEE INFORMATION

NAME	LICENSE NUMBER

HOME ADDRESS (FULL)

HOME PHONE	CELL PHONE	EMAIL

PLACE OF EMPLOYMENT	WORK PHONE

EMPLOYMENT ADDRESS (FULL)

JOB TITLE	WORK EMAIL

WORK SCHEDULE	INDICATE HOURS WORKING PER WEEK
☐ Full-time ☐ Part-time	

ARE YOU AND THE SUPERVISOR EMPLOYED BY THE SAME AGENCY?
☐ Yes ☐ No (if you check no, please answer the question below)

IF NO, HAS THE SUPERVISOR SECURED AN AGREEMENT WITH THE AGENCY AS TO THE PURPOSE OF CONTENT OF THE DESIRED SUPERVISION AND THE SUPERVISOR'S SPECIFIC ROLE, RESPONSIBILITIES AND LIMITATIONS?
☐ Yes ☐ No

SUPERVISOR INFORMATION

NAME	LICENSE NUMBER

PLACE OF EMPLOYMENT

CONTACT ADDRESS (FULL)

CONTACT PHONE	CELL PHONE	EMAIL

SUPERVISION SCHEDULE

BEGINNING DATE OF SUPERVISION

SUPERVISION FORMAT
☐ Individual ☐ Group ☐ Combination
Group supervision is acceptable only if there are no more than 6 in the group, and such supervision does not exceed one-half of the total supervisory time.

METHODS OF SUPERVISION
☐ Direct observation ☐ Chart audits ☐ Consultation ☐ Other
If you checked other, please explain _____

SUPERVISION PROCESS

SUPERVISEE JOB TITLE

DESCRIBE THE SUPERVISEE'S WORK SETTING(S) - NOTE, THE PROFESSIONAL SETTING SHALL NOT INCLUDE A PRIVATE PRACTICE IN WHICH THE SUPERVISEE OPERATES, MANAGES OR HAS AN OWNERSHIP INTEREST IN THE PRIVATE PRACTICE

DESCRIBE THE CLINICAL SERVICES THE SUPERVISEE WILL PROVIDE

DESCRIBE THE SUPERVISEE'S DUTIES AND RESPONSIBILITIES INCLUDING TREATMENT METHODS UTILIZED

SUPERVISION PROCESS (CONTINUED)

FORMULATE FIVE GOALS FOR THE SUPERVISION

1. _____

2. _____

3. _____

4. _____

5. _____

ATTACHMENTS TO INCLUDE WITH REGISTRATION OF SUPERVISION

☐ Employment verification on employer letterhead
☐ $25 Registration Fee - Payable to the Division of Professional Registration for the initial registration
☐ Copy of supervisor's 16 hour supervision training certificate or most recent update

AFFIDAVIT OF UNDERSTANDING AND SIGNATURES

☐ I understand that I must observe and comply with the supervision guidelines set forth in 20 CSR 2263-2.031 of the rules.

Under penalties of perjury, I declare and affirm that the statements made in the supervision plan, including accompanying statements, are true, complete and accurate. I understand that any false or misleading information in, or in connection with my supervision plan may be cause for denial or loss of supervision time received/and or loss of licensure. I understand I must submit the original of this form within 14-days of beginning supervision.

SUPERVISEE SIGNATURE	DATE
SUPERVISOR SIGNATURE	**DATE**

The *original* of this form and any attachment(s) must be mailed to the State Committee for Social Workers, P.O. Box 1335, Jefferson City, MO 65102 *within 14 days of beginning supervision or having a change of status*.

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

RECORD OF SUPERVISION

SUPERVISEE NAME			
DATE	**TIME START/END**	**INDIVIDUAL OR GROUP MEETING**	**FORMAT USED OR METHOD USED:** (Client/Case Discussion, Observation, Documentation Review, Clinical Test Content Review, Other-List)
1/1/2019	**1 p.m. - 2 p.m.**	**Individual**	**Client Discussion**

In signing this form, we verify that the recorded supervision sessions are accurate.

SUPERVISEE	SUPERVISOR

THIS IS TO BE ATTACHED TO THE ANNUAL REPORTS, SUPERVISION TERMINATION FORM AND ATTESTATION.