Wisconsin Department of Safety and Professional Services

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MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

DOCUMENTATION OF SUPERVISED CLINICAL FIELD PLACEMENT OR SUPERVISED CLINICAL SOCIAL WORK EXPERIENCE FOR CLINICAL SOCIAL WORKER LICENSE

APPLICANT: Complete this section and submit directly to your supervisor for completion. Form must be returned directly from the supervisor to the Department.

Name of Applicant	**Application Number**

Please check the appropriate box.

☐ Supervised clinical field training was completed during the Master's or Doctoral degree program.
If this box is checked, go to Part I.

☐ Supervised clinical social work experience was completed in lieu of supervised clinical field training.
If this box is checked, go to Part II.

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations. I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature (If unable to provide a digital signature, print and sign form.)	**Date**
	____/____/_____

PART I - DOCUMENTATION OF CLINICAL FIELD PLACEMENT (as part of Master's or Doctoral program)

SUPERVISOR: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Clinical Field Training per Wis. Admin. Code § MPSW 2.01(7)
"Clinical Field Training" means a minimum of one academic year in the supervised practice of clinical social work services consisting of assessment; diagnosis; treatment, including psychotherapy and counseling, client-centered advocacy, consultation, and evaluation. "Clinical Field Training" does not include indirect social work service, administrative, research, or other practice emphasis as per Wis. Admin. Code § MPSW 2.01(7).

Supervised Clinical Field Training per Wis. Admin. Code § MPSW 2.01(17)
"Supervised Clinical Field Training" means training in a primary clinical setting, which must include at least 2 semesters of field placement where more than 50% of the practice is to assess and treat interpersonal and intrapsychic issues in direct contact with individuals, families, or small groups as per Wis. Admin. Code § MPSW 2.01(17).

Primary Clinical Setting per Wis. Admin. Code MPSW § 2.01(13)
"Primary Clinical Setting" means a Facility, or a unit within a Facility, whose primary purpose is to treat persons with a DSM diagnosis as per Wis. Admin. Code § MPSW 2.01(13).

Note: If you completed 2 semesters of field placement to meet this requirement and the placements were in different settings, a separate form must be submitted for each placement.

PART I Supervisor completion continued on next page.

Wisconsin Department of Safety and Professional Services

Continued - PART I SUPERVISOR DOCUMENTATION of CLINICAL FIELD PLACEMENT (as part of Master's or Doctoral program)			
Name of Agency/Facility where field placement occurred: (Please type or print in ink.)			
Address of Agency/Facility where field placement occurred: (#/street)	(city)	(state)	(zip code)

Brief description of Agency/Facility including services provided and type of clients served: (Please type or print in ink.)

Is the Agency/Facility where the field placement was completed a "Primary Clinical Setting" as defined above in Wis. Admin. Code § MPSW 2.01(13)? ☐ Yes ☐ No

Was more than 50% of the practice in this Agency/Facility to assess and treat interpersonal and intrapsychic issues in direct contact with individuals, families, or small groups per Wis. Admin. Code § MPSW 2.01(17)? ☐ Yes ☐ No

Was this a block placement? ☐ Yes ☐ No **If no, for how many semesters was this placement?** _____

Dates of Field Placement:	**From:** ____/____/_____	**To:** ____/____/_____
	From: ____/____/_____	**To:** ____/____/_____

Please check the appropriate boxes:

☐	**I am/was the Agency/Facility-based Field Placement/Training Supervisor for the applicant.**
☐	**I am/was the Faculty Liaison with responsibility for this applicant's Field Placement/Training.**
☐	**I am/was the Director/Coordinator of Field Placement/Training.**
☐	**Other, please explain fully:**

Please check the appropriate boxes for each clinical social work service the student provided:

☐	**Assessment including difficulties in psychosocial functioning.**
☐	**Diagnosis including use of the DSM.** (This means that it is reasonable to expect that this student could describe client symptoms accurately, complete a differential DSM diagnosis and write a treatment plan based on that diagnosis.)
☐	**Treatment including psychotherapy and counseling including the ability to identify and describe the particular modality used.**
☐	**Client-centered advocacy.**
☐	**Consultation** (This means that the student can identify those case situations that require consultation and can present a clinical case.)
☐	**Evaluation including the process of evaluating the effect of his/her practice on the client's treatment goals/objectives and the progress of the client through treatment.**

PART I Supervisor completion continued on next page.

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Continued - PART I SUPERVISOR DOCUMENTATION of CLINICAL FIELD PLACEMENT (as part of Master's or Doctoral program)	
ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.	
Signature of Supervisor (If unable to provide a digital signature, please print and sign form.)	**Date**
	____/____/_____
Printed Name of Supervisor	**Phone**
Title	**Credential Number**

PART II – In lieu of supervised clinical field training, applicants may submit an affidavit indicating they have completed 1,500 hours of supervised clinical social work experience in not less than one year, within a primary clinical setting. This must include at least 500 hours of face-to-face client contact and be supervised per Wis. Admin. Code § MPSW 4.01.

SUPERVISOR: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

NOTE: These hours may not be counted towards the 3,000-hour requirement for post-graduate clinical experience. A separate form must be submitted for each site.

Name of Facility at which supervised clinical social work experience occurred:			
Address of Agency/Facility where experience occurred: (number/street)	(city)	(state)	(zip code)

Dates of Experience:	**From:** ____/____/_____	**To:** ____/____/_____
Number of Hours Completed:		
Name of Supervisor:		
Title of Supervisor:		

I hereby swear or affirm that the statements made above are true and correct.

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Supervisor (If unable to provide a digital signature, print and sign form.)	**Date**
	____/____/_____
Credential Number	**Phone Number**