

Wisconsin Department of Safety and Professional Services

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

SUPERVISOR'S AFFIDAVIT FOR EMPLOYMENT/INTERNSHIP

APPLICANT: This affidavit must be completed and returned directly by the applicant's supervising social worker who holds a current, unrestricted, State of Wisconsin social work certification to the Department. Per Wis. Admin. Code § [MPSW 3.13\(3\)\(b\)](#), a supervising social worker must have a Bachelor's or Master's Degree in Social Work. A social worker who obtained social work certification by completing a Wisconsin Social Work Training Certificate may not provide supervision.

Name of Applicant:	<input type="text"/>
Application Number:	<input type="text"/>
Supervisor's Name:	<input type="text"/>
Supervisor's Degree:	<input type="checkbox"/> BSW <input type="checkbox"/> MSW
Supervisor's Lic'd Profession:	<input type="text"/>
Supervisor's Credential #:	<input type="text"/> - <input type="text"/>

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 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 provision of the information asked of them directly to DSPS. I also declare that to the best of my knowledge the verification will be 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.

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Applicant Signature (If unable to provide a digital signature, print and sign form.)	Date

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.)

The above-listed applicant has completed one or more of the following and I have provided direct, onsite supervision of the above-named applicant in a human services internship or employment which involved direct practice with clients and which provided training and experience in all required areas per Wis. Admin. Code § [MPSW 3.13\(3m\)](#).

- Internship (400 hours) part of the internship program must qualify for the social work training certificate.
- Social Work Employment (400 hours of face-to-face client contact in not less than 12 months per Wis. Admin. Code § [MPSW 3.13\(3\)\(b\)](#).

Continued on next page.

Wisconsin Department of Safety and Professional Services

Supervisor completion, continued.

SUPERVISION REQUIREMENTS:

Consistent with Wis. Admin. Code § [MPSW 3.13\(4\)](#), supervision must include the direction of social work practice in a face-to-face individual session of at least one hour duration during each week of supervised practice of social work, and shall further comply with Wis. Admin. Code §§ [MPSW 4.01\(1\)](#) and [\(3\)](#). (Wisconsin Statutes and Administrative Code is available on the DSPS website at dps.wi.gov. Select "PROFESSIONS," then "Social Worker - Training Certificate," and "Statutes and Administrative Code.")

Dates applicant was under my supervision: From: / / To: / /

In the process of gathering hours of supervised social work experience as defined by [Wis. Stat. § 457.01\(9\)](#), this applicant accumulated,

hours of face-to-face client contact. During this time, I met with the applicant for

hours of face-to-face supervision.

I certify that I have reviewed and complied with Wis. Admin. Code § [MPSW 3.13\(4\)](#) and Wis. Admin. Code §§ [MPSW 4.01\(1\)](#) and [\(3\)](#) which set guidelines for supervision of social work practice in Wisconsin.

was signed on: / /

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.

/ /

Supervisor's Signature (If unable to provide a digital signature, print and sign form.)

Date

- -

Printed Name

Phone

Facility Name

Title

Facility Address (number/street)

(city)

(state)

(zip code)