

Wisconsin Department of Safety and Professional Services

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

DOCUMENTATION OF POSTGRADUATE CLINICAL EXPERIENCE WHEN SUPERVISOR IS UNAVAILABLE

Pursuant to Wis. Admin. Code § [MPSW 3.09\(3\)](#) or [\(3m\)](#), an applicant for licensure as a clinical social worker must complete at least 3,000 hours of clinical social work practice, including at least 1,000 hours of face-to-face client contact including DSM diagnosis and treatment of individuals, under the supervision of a supervisor approved by the Social Work Section after receiving a master's or doctoral degree. Supervised practice shall meet the criteria under Wis. Admin. Code § [MPSW 4.01](#). If a supervisor is unavailable to sign Form 2560, Applicant must complete the following for consideration of waiver of the supervisor's signature. Requests for waiver of supervisor's signature on [Form 2560](#) will be considered on a **case-by-case basis and will only be granted in exceptional cases.**

Applicant: Complete this section.

Applicant Name (First, Middle, Last)		Application Number	
Name of postgraduate clinical experience facility			
Facility address (number/street)	(city)	(state)	(zip code)

Supervisor Information

Supervisor Name		Type of Credential Held	Credential No./State
Dates under supervision	From ____ / ____ / ____	To ____ / ____ / ____	
Number of hours of face-to-face client contact: _____			
Number of hours of face-to-face individual or group supervision: _____			
Total number of hours of clinical social work practice: _____			

Briefly describe facility's mission:

Briefly describe the clients served at facility:

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Please indicate why your supervisor is unavailable to sign [Form 2560](#) and submit any supporting documentation.

- Death of supervisor.
- Temporary military deployment of supervisor.
- Other exceptional circumstances: **Explain below.** Please include a description of the efforts taken to obtain the supervisor's signature on Form 2560. Attach additional sheets as needed.

Please describe, in detail, your experience as follows: (Attach additional sheets if necessary.)

1. What experience do you have providing therapy, including the type of client and treatment modality?

2. Were you the primary provider of psychotherapy services for your clients? **If no, please explain.**

3. How were you involved in diagnosing clients using the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)?

4. Do you have the ability to change or recommend changing a client's DSM diagnosis? Please describe.

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Evaluation of Applicant: To complete the supervision requirements, I understand that I must demonstrate minimum competency in the areas listed below. Please check whether you meet the minimum competencies in each area listed below and provide any additional materials to support these claims. Applicants can attach a resume/CV and other documentation to demonstrate minimum competency, and the requirements set forth Wis. Admin. Code § [MPSW 3.09\(3\)](#) or [\(3m\)](#) in the areas listed below.ⁱ

1.	Application of an Evaluation and Assessment - I can evaluate and assess difficulties and strengths in psychosocial functioning of a group or individual.	___ Yes ___ No
2.	Application of a Differential Diagnosis – I can demonstrate skill in the application of a differential diagnosis, and I am able to apply client symptoms and behaviors in formulating a diagnosis pursuant to the DSM.	___ Yes ___ No
3.	Establishing and Monitoring a Treatment Plan – I can demonstrate skill in establishing and monitoring a treatment plan, and I am able to apply the components of the treatment plan to the diagnostic assessment.	___ Yes ___ No
4.	Development and Appropriate Use of the Professional Relationship – I can demonstrate skill in the development and appropriate use of the professional relationship, and I am able to apply the necessary skills to develop a professional relationship in the phases of the treatment process including intervention, counseling of individuals, families, and groups; psychotherapeutic services to individuals, families, and groups.	___ Yes ___ No
	I have the skills and knowledge necessary to practice psychotherapy independently.	___ Yes ___ No
	I can make an accurate DSM diagnosis.	___ Yes ___ No
	I can provide appropriate treatment without supervision.	___ Yes ___ No
5.	Professional Identity and Ethics	___ Yes ___ No
	I use supervision and show continuing development of clinical skills.	___ Yes ___ No
	I demonstrate knowledge of strengths and limitations of a clinical social worker and the distinctive contributions of other mental health and health professionals.	___ Yes ___ No
	I make appropriate referrals to other health providers and resources in the community.	___ Yes ___ No
	I know and understand the laws related to life-threatening situations, child abuse, elder abuse, physical abuse, etc.	___ Yes ___ No
6.	Case Management and Record Keeping - I maintain appropriate clinical records and client data and understand the circumstances under which various records can be released.	___ Yes ___ No

Attestation of Applicant: I declare, by signing below, that I am the individual named above and that all information provided is true. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information may result in 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, understand, and have complied with the above declarations.

Signature	Date (mm/dd/yyyy)
	____ / ____ / _____

(Provide a digital signature or print and sign form.)

ⁱ Applicants might demonstrate competency by showing five years or more of relevant practice in the field as determined by the Section.