# Wisconsin Department of Safety and Professional Services

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**LicensE Portal:** License.wi.gov
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

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

## DOCUMENTATION OF POSTGRADUATE CLINICAL EXPERIENCE – SUPERVISOR'S AFFIDAVIT FOR SOCIAL WORK LICENSE

An affidavit is required that the applicant, after receiving a master's or doctoral degree, has completed at least 3,000 hours of clinical social work practice, including at least 1,000 hours of face-to-face client contact and 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.

**APPLICANT:** Complete this section and submit directly to your supervisor for completion. Form must be returned directly from the supervisor to the Department. (Copy this form for completion by each supervisor and/or facility.)

| **Applicant Name** | **Application Number** |
|---|---|
| | |

**Name of postgraduate clinical experience facility**

| **Facility address** (number/street) | (city) | (state) | (zip code) |
|---|---|---|---|
| | | | |

**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.

**Applicant Signature** (If unable to provide a digital signature, please 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.)

| **Supervisor Name** | **Type of Credential Held** | **Credential Number** |
|---|---|---|
| | | |
| **Dates the applicant was under your 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 your facility's mission _____

Briefly describe the clients served at your facility _____

**Please describe, in detail, the applicant's experience as follows: (Attach additional sheets if necessary.)**

1. What experience does this applicant have providing therapy, including the type of client and treatment modality?

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***Supervisor completion, continued.***

2. Was the applicant the primary provider of psychotherapy services for his or her clients? **If no, please explain.**

3. How has this applicant been involved in doing and/or consulting in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis of clients?

4. Does the applicant have the ability to change or recommend changing a client's DSM diagnosis?

**EVALUATION OF APPLICANT:** To complete the supervision requirements, applicants must demonstrate minimum competency in the areas listed below. Please check your evaluation of the applicant in each area listed below.

| | | |
|---|---|---|
| 1. | **Application of an Evaluation and Assessment -** Applicant was able to evaluate and assess difficulties and strengths in psychosocial functioning of a group or individual. | ☐ Yes ☐ No |
| 2. | **Application of a Differential Diagnosis -** Applicant was able to demonstrate skill in the application of a differential diagnosis and was able to apply client symptoms and behaviors in formulating a diagnosis pursuant to the DSM. | ☐ Yes ☐ No |
| 3. | **Establishing and Monitoring a Treatment Plan -** Applicant was able to demonstrate skill in establishing and monitoring a treatment plan, and was able to apply the components of the treatment plan to the diagnostic assessment. | ☐ Yes ☐ No |
| 4. | **Development and Appropriate Use of the Professional Relationship** - Applicant was able to demonstrate skill in the development and appropriate use of the professional relationship and was 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 |
| | Applicant has the skills and knowledge necessary to practice psychotherapy independently. | ☐ Yes ☐ No |
| | Applicant can make an accurate DSM diagnosis. | ☐ Yes ☐ No |
| | Applicant is able to provide appropriate treatment without supervision. | ☐ Yes ☐ No |
| 5. | **Professional Identity and Ethics** | |
| | Applicant uses supervision and shows continuing development of clinical skills. | ☐ Yes ☐ No |
| | Applicant demonstrates knowledge of strengths and limitations of a clinical social worker and the distinctive contributions of other mental health and health professionals. | ☐ Yes ☐ No |
| | Applicant makes appropriate referrals to other health providers and resources in the community. | ☐ Yes ☐ No |
| | Applicant knows and understands the laws related to life-threatening situations, child abuse, elder abuse, physical abuse, etc. | ☐ Yes ☐ No |
| 6. | **Case Management and Record Keeping** - Applicant maintains appropriate clinical records and client data and understands the circumstances under which various records can be released. | ☐ Yes ☐ No |

**All supervisors are legally and ethically responsible for the activities of the social work supervisee. Supervisors shall be available or make appropriate provision for emergency consultation and intervention. Supervisors must be able to interrupt or stop the supervisee from practicing in given cases and to stop the supervised relationship if necessary.**

I certify all the information on this affidavit to be true.

**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** (If unable to provide a digital signature, please print and sign form.) **Date** __/__/____

**Title:** _____ **Phone:** ___-___-____