Arkansas Department of Health
Social Work Licensing Board
5800 West 10th, Suite 100, Little Rock, AR 72204 * (501) 372-5071 * Fax (501) 372-6301
Mailing Address: P. O. Box 251965, Little Rock, AR 72225
swlb@arkansas.gov * http://www.arkansas.gov/swlb/
Governor Asa Hutchinson
José Romero, MD, Secretary of Health
Ruthie Bain, Director

Check if this is an update

Supervision Plan
Update Effective Date: __________

INSTRUCTIONS: Read the Supervision Guidelines. This plan must be submitted to the Board within 60 days from the beginning date of supervision. The Board does not send confirmation of receipt for mailed or faxed forms. You may follow-up with the Board’s office by email or phone call to make sure the Plan has been received.

Please use updated forms and keep a copy for your records. This form is not meant to be modified. Please Print. Emailed Plans will be acknowledged as received and the reply will serve as your confirmation.

Supervisee Information:
Name: __________________________________________ License Number: __________________________
Home Address: (full) __________________________________________ (Please note: If this has changed you must submit a change of address form – available on website.
Home Phone: ___________ Cell Phone: ___________ Email: __________________________
Place of Employment: __________________________________________ Work Phone: ___________
Employment Address: (full) __________________________________________
Job Title: __________________________________________ Work Email: __________________________
Work Schedule: _____ Full-time _____ Part-time (Total hours employed in a social work position must equal 4,000 hrs.)
Are you and the supervisor employed by the same agency? _________ Yes _________ No If not, you must attach a letter from the agency supervisor or administrator stating that the supervisor has access to the pertinent records and/or policies. Permission must be on Letterhead stationery and signed. The date must agree with the beginning date of supervision.

Supervisor Information: Effective July 1, 2020, the LCSW must have been licensed as a LCSW for at least three (3) years. Does not apply to updates of current plans.
Name: __________________________________________ License Number: ___________
Place of Employment: __________________________________________
Home Address: (full) __________________________________________
Home Phone: __________________________ Cell Phone: __________________________
Supervision Schedule: Beginning Date of Supervision: __________

Supervision Sessions Hours Per Month: Individual: __________ Group: __________ Total: __________
Methods of Supervision: Direct observation: __________ Chart audits: __________ Peer Review: __________ Other: __________

If other, please explain __________________________________________
01/11/2021
**Supervision Process:**
Describe the supervisee’s job duties: __________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Describe the clients served: ______________________________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Describe the supervisee’s work setting and responsibilities including treatment methods utilized: __________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Formulate five goals for the supervision: (Please use sentence form)
1. ______________________________________________________________________________________
2. ______________________________________________________________________________________
3. ______________________________________________________________________________________
4. ______________________________________________________________________________________
5. ______________________________________________________________________________________

Comments: __________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Please initial the appropriate box(es): BOTH LCSW and LMSW

**Attachment to include with Supervision Plan:**
_____ _____ If the supervision of agency-based clients is done outside the agency setting, a letter from the agency supervisor or administrator must be attached. The letter **must** state that the supervision is approved and that the LCSW supervisor has access to the pertinent records and/or policies. The letter must be on letterhead stationery and signed. The permission letter **MUST** be dated on or prior to the beginning date of supervision.

**Affidavit of Understanding and Signatures:**
_____ _____ We hereby certify that prior to beginning supervision We have read and reviewed the rules and forms pertaining to LCSW supervision. We understand that we must observe and comply with the supervision guidelines set forth in the rules.

*Under penalties of perjury, we declare and affirm that the statements made in the supervision plan, including accompanying statements, are true, complete and accurate. We 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. We understand we must submit this form within 60-days of beginning supervision. We have read the LCSW Supervision Guidelines. Please review form for completeness!*

Supervisee Signature __________________________________________________________ Date _____________

Supervisor Signature __________________________________________________________ Date _____________

This form and any attachment(s) must be sent by the supervisee to the Social Work Licensing Board, **within 60 days of beginning supervision**. Forms received after 60 days only count back 60-days from date received or post marked.

Below this line for board use only

Plan reviewed by: __________________________ Date: _____________ Plan Received on: __________________________

Board Member Signature

Incomplete forms will be returned, please make sure all banks are complete before sending.