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 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:

Please check Supervision Format: _____ Individual _____ Group _____ Combination
Group supervision is acceptable only if there is a maximum of four supervisees in the group, and such supervision does not exceed one-half of the total supervisory time.

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 that reflect what the supervisee intends to learn or accomplish with their supervisor within the one (1) hour weekly supervision: Please use complete sentences. Do not include job duties, studying for the exam, weekly staff meetings, completing supervision, job duties or obtaining continuing education hours. You may attach an additional sheet if needed for your goals. Make sure to list your name on the additional sheet and write see attached below.

1._____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

_____

*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 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 blanks are complete before sending.