



Arkansas Department of Health

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Social Work Licensing Board

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Supervision Plan

___ Check if this is an update

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.

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 no, 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.

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 Sessions Hours Per Month: Individual: _____ Group: _____ Total: _____

Methods of Supervision: Direct observation: _____ Chart audits: _____ Peer Review: _____ Other: _____

If other, please explain _____

08/06/2020

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)

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.

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.***

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.