IDAHO STATE BOARD OF SOCIAL WORK EXAMINERS
Idaho Bureau of Occupational Licenses
700 W State Street, Boise ID 83702 or
PO Box 83720, Boise, ID 83720-0063
Phone: (208) 334-3233 Fax: (208) 334-3945
Website: www.ibol.idaho.gov E-mail: swo@ibol.idaho.gov

INSTRUCTIONS FOR APPLICATION FOR APPROVAL OF SUPERVISOR and SUPERVISION PLAN FOR CLINICAL LICENSURE

Your application is the first step in the process of becoming licensed by The Idaho Board of Social Workers as a Licensed Clinical Social Worker. These instructions are to guide you through the application to prevent possible delay in the approval of your application and beginning supervision.

The purpose of the supervision plan is to insure that the applicant will be providing, with approved supervision, clinical social work services in the appropriate manner as defined by Idaho statutes.

Please print forms directly from the Board's webpage. ***Submitting outdated applications and incomplete responses may delay the processing time.***

Please spell out the first reference to any acronym. For example Idaho Board of Social Work Examiners (ISBSWE).

Applicant: identifies you, your place of employment and your work schedule.
Supervisor(s): identifies your supervisor(s) and their contact information.
Clinical Supervision: indicates if your place of employment is providing your supervision or if you are contracting supervision outside your place of employment. If your supervision is by your employer, the board wants to know how it will be separate from administrative supervision. What will be the format of your supervision and the number of hours of supervision you will receive each month?
Supervision Information: This section is to answer the questions: Where, who and what of clinical work.
Work setting(s): (**Where**) Identifies where you are working both by name (ABC Behavioral Health, XYZ Psychiatric Hospital), and by industry (mental health clinic, hospital, state agency etc.).
Clients served: (Who) Identifies your client population by their most common identifiable characteristics. Include common presenting problems, age, gender, socio-economic status or any other information that will help the board in understanding the clients you serve.
Duties and responsibilities: (**What**) Identifies your clinical work. What are you doing in providing DSM-5, TR diagnosis? Is this your duty alone or in consultation? Identify assessments you are to be conducting. Treatment methods utilized should include both format (individual, group, couples, families, etc.) and technique (DBT, Play therapy, CBT, Gestalt, etc.). Please be aware that some of your job responsibilities may not count toward the three thousand hours required to complete clinical supervision.
Five goals for supervision: You and your approved supervisor will determine areas of professional growth, personal awareness or skills that will assist you in increasing your clinical competence.
Methods of supervision: Your supervisor will indicate the methods of supervision to be utilized.
Agency Director Signature: This provides you and the board written record that the agency director is aware and supports your efforts to perform supervised clinical social work services.
Signatures: You and your clinical supervisor will need to have your signatures notarized.
If you have questions about the application we recommend you contact the Idaho Board of Social Work Examiners prior to submission.

NOTE: Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period. Failure of the supervisor to submit the required reports in a timely manner may result in the supervisor being restricted by the Board from providing further supervision. Please use the form and answer questions within the provided space. **Please keep copies for your records, your agency and your supervisor.**

NOTE to SUPERVISEE (APPLICANT): Supervision must be provided by a clinically Licensed Idaho Social Worker registered as a supervisor, a Licensed Idaho Clinical Professional Counselor registered as a supervisor, a Licensed Idaho Marriage and Family Therapist registered as a supervisor, or a Licensed Idaho Psychologist or Licensed Idaho Psychiatrist. Information and materials necessary to start the supervision process will be sent to you and **YOU MAY NOT ACCUMULATE HOURS AND YOUR SUPERVISED EXPERIENCE MAY NOT COMMENCE UNTIL YOUR SUPERVISORS ARE REGISTERED AND THE BOARD APPROVES YOUR SUPERVISION PLAN.**

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APPLICATION FOR APPROVAL OF SUPERVISOR and SUPERVISION PLAN FOR CLINICAL LICENSURE

This application is to notify the Idaho Board of Social Work Examiners of my intent to begin the supervision required for clinical licensure.

Applicant (supervisee) Name________________________________License #______________

Phone (_____)_______________E-mail _____________________________________

Place of Employment: ____

Mailing address____
Street/PO Box City State Zip

Business address____
Street/PO Box City State Zip

Are you currently under another approved supervision plan? _____Yes _____No

If yes, and you are planning to continue being supervised by that supervisor, please note the name of the supervisor and current hours of supervision:____

If you are switching supervisors, please clarify the reason:__________________________________

Work Schedule: ☐ Full time (30hrs/wk) or more ☐ Part time (Hours per week_______)

Supervisor Information: Primary Supervisor ☐ or Secondary Supervisor ☐

Supervisor Name:_______________________________________License #______________

Are you a board-approved supervisor? Yes___________No______________

Business Name____

Business Address____

Mailing Address ____

Phone (_____)_________________E-mail______________________________________

Supervision Information - ***Please provide a detailed accounting of what your professional exposure will be in each of the following categories:***

1. Describe the supervisee's work setting(s): _____________________________________

____

____

____

2. **Describe the types of clients you will be serving (for example; substance abuse, ADHD, domestic abuse, etc):**

3. **Please include specific information for each of the following categories:**

Please describe the **Assessment** process and include any instruments you will be using:

Please describe how you will use **Diagnostics** in this setting:

Please describe the **Treatments, Modalities, and Techniques** you will be using in this setting:

4. Clinical Supervision

4a. Please specify how supervision is provided (choose one):

_☐_ contracted

_☐_ within agency framework **(If within agency, use the space below to describe how is it separated from agency supervision.)**

____

____

____ BOTH

4b. Supervision format: ☐Individual ☐Group ☐Combination

4c. Supervision Hours **<u>per Month</u>**: Individual_______Group______=______Total Hours

NOTE: If using group supervision, please use the following form to calculate group hours:

Total session minutes_____÷ number of supervisees_____=_______Total
(do not include your supervisor)

Total from previous line x 2 =______total maximum allowable time per supervisee for each group session (enter this total on line 4c. for "Group" and add it to individual hours for total on line 4c.).

Rule 210.b.ii regarding group supervision states:

Group supervision may count for no more than fifty (50) hours of face-to-face contact. Group supervision may count only where the ratio of supervisor to supervisees does not exceed one (1) supervisor to six (6) supervisees, and the allowable countable time shall be prorated by the following formula: total session minutes divided by total supervisees, multiplied by two (2) equals the maximum allowable countable time per supervisee for the session

Examples:

2 supervisees counts for 60 minutes of the hour.

3 supervisees counts for 40 minutes of the hour.

4 supervisees counts for 30 minutes of the hour.

5 supervisees counts for 24 minutes of the hour.

6 supervisees counts for 20 minutes of the hour.

5. Formulate five goals for the supervision (please be sure that these goals emphasize treatment and diagnostics):

I.____

II.____

III.____

IV.____

V.____

6. Methods of supervision to be used ____

____

____

I have reviewed the clinical supervision plan and am in support of the arrangement.

Print Agency Director Name: ____

Agency Director Signature:________________________________Date __________________

Applicant Affidavit

I hereby agree to comply with the supervision plan outlined herein as part of my application for social work clinical licensure. I certify that I have reviewed and understand the plan and its requirements and procedures for supervision of my practice and that I will comply with those requirements and procedures in my practice pursuant to the plan.

____
Signature of Applicant

State of______________, County of_________________, ss.
Subscribed and sworn before me this______day of_______________________, 20_____.

(seal) ____
Notary Public Official Signature
My Commission Expires_______________________

Supervisor Affidavit

I hereby agree to serve as the supervisor of the applicant in the supervision plan outlined herein as a part of the applicant's application for social work clinical licensure. I certify that I have reviewed and understand the plan and its supervision requirements and procedures and that I will follow those requirements and procedures in my supervision of the applicant's practice pursuant to the plan.

Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period. Failure of the supervisor to submit the required reports in a timely manner may result in the supervisor being restricted by the Board from providing further supervision.

____
Signature of Supervisor

State of______________, County of_________________, ss.
Subscribed and sworn before me this______day of_______________________, 20_____.

(seal) ____
Notary Public Official Signature
My Commission Expires_______________________

PLEASE NOTE THAT UNDER RULE 210, YOU MAY NOT ACCUMULATE HOURS AND SUPERVISED EXPERIENCE MAY NOT COMMENCE UNTIL YOUR SUPERVISORS ARE REGISTERED AND THE BOARD APPROVES YOUR SUPERVISION PLAN.