

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 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.**

Incomplete responses may delay your application.

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APPLICATION FOR APPROVAL OF SUPERVISOR and SUPERVISION PLAN FOR CLINICAL LICENSURE
This application is to notify the 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

This plan reflects only a change in supervisor () Yes () No

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

1. Describe the supervisee's work setting(s) _____

2. Describe the client's served _____

3. Describe the supervisee’s duties and responsibilities including **diagnosis, assessments and treatment methods utilized (please include specific information for each:**

Assessment: _____

Diagnosis: _____

Treatment Methods: _____

4. Clinical Supervision

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

_____ contracted or

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

4b. Supervision format: () Individual () Group () Combination

4c. Supervision Hours per Month: 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.