

IDAHO STATE BOARD OF SOCIAL WORK EXAMINERS
Bureau of Occupational Licenses
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Boise, ID 83720-0063
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Out-of-State Clinical Social Work Supervisor Verification Form

NAME OF SUPERVISEE: _____

DATES OF SUPERVISION PERIOD: From: _____ To: _____

STATE WHERE SUPERVISOR IS LICENSED _____

STATE LICENSURE NUMBER: _____ LICENSURE LEVEL: _____

LENGTH OF TIME LICENSED _____

1. Number of Clinical hours performed by the supervisee: _____
2. Number of indirect hours: _____
3. Number of hours of direct client contact: _____
4. Number of individual supervision hours: _____
5. Evaluation of your supervisee, including clinical skills and knowledge and his/her application of knowledge and skills in clinical work. (Please feel free to use additional space as needed)

6. Briefly describe the setting in which the supervisee's clinical work was performed.

7. Do you have any reservations regarding the supervisee's ability to perform as a clinical social worker? If so, please explain. (Please use additional space as needed)

My supervisor has discussed the information in this report with me. _____
Signature of Supervisee Date

Print Supervisor Name: _____ Discipline & Degree _____

License Number (include State of licensure) _____
Supervisor Signature _____

On this ____ day of _____, 20__, before me a notary public and in for said state, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and being first duly sworn by me acknowledged to me that (s)he executed the same and that the statements therein contained are true.

State of _____, County of _____, ss.

Subscribed and sworn before me this ____ day of _____, 20 ____.

(seal)

Notary Public official signature

My Commission Expires _____

Please note this document will become part of the applicant's file and the applicant has the right to request anything from the file.