DOCUMENTATION OF CLINICAL SUPERVISION FOR LCSW
Information Sheet (complete one for each supervisor)

Name of LSW: ____

Date LSW received: ______________________ ☐ License attached (copy)

Address: ____

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Email(s): ____

Phone(s): ____

Name of Supervisor: ____

Date LCSW received: ____
(minimum 3 years ago)

Address: ____

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Email(s): ____

Phone(s): ____

Provider/Date of Clinical Supervision course: ______________________________________
(July, 2004 or more recently)

☐ License attached (copy) ☐ Clinical Supervision certificate attached (copy)

____________________________________ ____________________________________
Signature of LSW **Print Name**

____________________________________ ____________________________________
Signature of LCSW **Print Name**

THESE FORMS RECORD CLINICAL HOURS THAT YOU HAVE WORKED AND THE CLINICAL SUPERVISION OF THESE HOURS. THEY DO NOT REPLACE THE SUPERVISION DOCUMENTATION FORM IN THE LCSW APPLICATION.