CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF SOCIAL WORK EXAMINERS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@delaware.gov

SUPERVISORY REFERENCE FORM

INSTRUCTIONS

This form is to be completed by the supervisor of the person applying for a Delaware Clinical Social Worker license. The form's purpose is to document that the applicant has acquired two years of post-MSW degree clinical social work experience consisting of at least 3,200 hours, of which at least 1,600 hours were under the supervision of a licensed clinical social worker (LCSW), master's level degree social worker (LMSW), licensed psychologist, or a licensed psychiatrist (24 *Del. C.* § 3907). During the period supervised, *at least one hour per week must be one-on-one face-to-face supervision* (See Board's Rules and Regulations).

1. Applicant Name: ______________________________

2. Supervisor Name: ______________________________

3. Enter this information about your agency (if applicable):

Agency Name	
Address	
Phone	

4. Enter this information about your education at the time you supervised the applicant:

University	
Field	
Degree and Date Conferred	

5. Enter this information about your license during the period you supervised this applicant:

Type of License	
License Number	
Issue Date	

6. **Total Clinical Supervised Hours:** _________ 7. **Total Hours of One-To-One Supervision:** _______________

8. Dates of Post Master's Supervised Clinical Social Work Experience: From: ______________ To: ______________
Month/Year Month/Year

9. Use of professional values and ethics, professional knowledge, professional identity and use of self and disciplined approach to the practice environment should be reflected in each of the practice skills listed below.

I attest that the applicant satisfactorily demonstrated the following practice skills during the 1600 hours of post-MSW degree professionally supervised clinical social work experience.	Answer each item:
Provides adequate clinical diagnoses and biopsychosocial assessments	Yes ☐ No ☐
Performs short-term and/or long-term interventions	Yes ☐ No ☐
Establishes treatment plans with measurable goals	Yes ☐ No ☐
Adapts interventions to maximize client responsiveness	Yes ☐ No ☐
Recognizes when personal issues affect clinical objectivity	Yes ☐ No ☐
Recognizes and operates within own practice limitations	Yes ☐ No ☐
Seeks consultation when needed	Yes ☐ No ☐
Refers to sources of help when appropriate	Yes ☐ No ☐
Practices within established ethical and legal parameters	Yes ☐ No ☐

I attest that the applicant named above worked under my clinical supervision. I certify that I personally completed all sections of this form and the information provided herein is accurate and complete to the best of my knowledge and belief.

Signature of Supervisor: ____ Date: ______________

UPLOAD THIS DOCUMENT WITH YOUR APPLICATION IN DELPROS