



CANNON BUILDING
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DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF SOCIAL WORK EXAMINERS

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EMAIL: customerservice.dpr@delaware.gov

VERIFICATION OF LICENSURE FORM

Section I – To be completed by applicant. Send form to jurisdictions where you are currently, or have ever been, licensed. ENTER YOUR APPLICATION ID: _____

Name: _____

License Type: _____ License Number: _____

Phone: _____ Email: _____

I hereby authorize _____ to release information regarding my licensure,
Name of state licensing Board/Authority
certification, or registration to the Delaware Board of Clinical Social Work Examiners.

Applicant Signature: _____ **Date:** _____

Section II - To be completed by State Licensure Board/Authority. Mail completed form *directly* to the Delaware Board at address above.

Date of Original Registration/Licensure: _____

Registration/License No: _____ Expiration Date: _____

Type of Examination: ASWB Clinical Other Specify: _____

Pass/Fail Status as Determined by ASWB: _____ Date of Examination: _____

Has the licensee ever been subject to any disciplinary action, or had his/her license suspended or revoked?
Yes No **If yes, enclose a certified copy of the board's final order.**

Are there current or pending disciplinary proceedings or unresolved complaints against the applicant? Yes No

I certify the statements contained herein are true and correct.

Name of Official: _____ Title: _____

Name of Licensure Authority: _____

Address: _____

_____ Phone: _____

AFFIX BOARD SEAL

Signature of Official: _____ **Date:** _____

Mail completed form directly to the Board office at the address above.