

Division of Public Health – Licensure Unit
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**FOR MASTER SOCIAL WORKER
POST-MASTER’S SUPERVISED EXPERIENCE
VERIFICATION**

IMPORTANT INSTRUCTIONS: Each supervisor **MUST** sign and date this form to attest to the experience earned. **These hours MUST be earned after receipt of an approved master’s degree.**

Supervisors must complete this attachment

PART I – Changes to information entered onto this form invalidates the form unless the supervisor initials their name beside the changed information (white out is not acceptable).

Name of Supervisor: _____ License #: _____

Name of Applicant: _____

Supervisor(s) place a checkmark in the box by your Credentials below:

- Licensed **Mental Health Practitioner**
- Licensed **Independent Mental Health Practitioner**
- Certified **Master Social Worker**

PART II – MASTER SOCIAL WORK EXPERIENCE:

SUPERVISORS: List only the hours that you personally supervised

1. Total number of hours of social work activities under my supervision: _____
(total hours)

2. Dates of supervision (**provide FULL dates**): from _____ to _____.

MSW Activities include:

1. Information, resource identification and development, and referral services
2. Preparation & evaluation of psychosocial assessments & development of social work service plans
3. Case management, coordination, and monitoring of social work service plans in the areas of personal, social, or economic resources, conditions, or problems
4. Development, implementation, and evaluation of social work programs and policies
5. Supportive contacts to assist individuals and groups with personal adjustment to crisis, transition, economic change, or a personal or family member's health condition
6. Social casework for and prevention of psychosocial dysfunction, disability, or impairment
7. Social work research, consultation, and education

Supervisor’s Signature

I state that I am the person completing this form and the statements on this form are true and complete
AND
I have supervised the hours reported above.

(Print/type) SUPERVISOR Name and Title

Date Signed : _____

Signature

AGENCY/INSTITUTION

STREET ADDRESS

CITY STATE ZIP