MINNESOTA
BOARD OF SOCIAL WORK

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Protecting the Public

CLINICAL SUPERVISION PLAN

INFORMATION & INSTRUCTIONS

Submit Supervision Plans and Supervision Verification forms using
'ONLINE SERVICES' or 'DOWNLOADABLE FORMS' at the Board's website

- **REVIEW BOARD STATUTE**: Review supervised practice requirements at the Board of Social Work website.
- **SUPERVISION PLAN REQUIRED:** Supervision Plans must be submitted to the Board within 60 days of beginning a social work position. Submit a:
  (1) revised plan within 60 days of a substantial change to your original plan;
  (2) a separate Supervision Plan form for each social work position;
  (3) one form for multiple supervisors submitted for the same position. Make copies of the supervisor page as needed.
- **COMPLETE FORM:** Complete and ***KEEP ALL PAGES TOGETHER.*** Incomplete forms will be returned and will result in delayed processing. Submit via email, fax, or mail.
- **DETAILED DESCRIPTION OF PRACTICE:** Attach a detailed description of clinical practice according to the instructions on page three of this form. All supervisors must sign the detailed description of practice.
- **SUPERVISION PLAN LATE FEE:** Supervision Plan late fee of $40 may be assessed at license renewal if the required Supervision Plan is not submitted within the 60-day deadline of beginning a social work position.
- **VERIFICATION REQUIRED:** Supervision Verification form is required at license renewal, or when applying for either the LISW or LICSW, to demonstrate compliance with Supervision Plan.

TENNESSEN WARNING

The Board is seeking data from you which may be considered private or confidential under the Minnesota Government Data Practices Act. Minn. Stat. sec. 13.04, subd. 2 requires the Board to notify you of the following four matters before you are asked to supply such information: (1) This data is being collected to determine whether you have violated any statutes or rules the Board is empowered to enforce and/or to determine whether you meet the requirements for licensure or renewal; (2) You are not legally required to provide the information requested, but failure to do so may result in the denial of the licensure application, and/or disciplinary or other action by the Board; (3) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action. (4) The data which you supply will be accessible to Board staff and may also be released to other persons or governmental entities that have statutory authority to review the data, investigate specific conduct, or take appropriate legal action, such as Board members and the Attorney General. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

LICENSEE/SUPERVISEE STATUS

I am submitting the following *(check one)*:

☐ **INITIAL PLAN**

☐ **REVISED PLAN** *(circle change)*

- New supervisor
- Additional supervisor
- Type or amount of supervision
- Employment
- Scope of position

LICENSE NUMBER:	CURRENT LICENSE: *(check one)* ☐ **LGSW engaged in clinical social work practice** ☐ **LISW engaged in clinical social work practice**	
LAST NAME *(as it appears on license card)*:	FIRST NAME:	MIDDLE NAME:

LICENSEE/SUPERVISEE CONTACT INFORMATION

You **MUST** provide a **PUBLIC** address and a **MAILING** address, and a **PUBLIC** phone number and a **PRIMARY** phone number, which can be the same or different.

- **PUBLIC** address and **PUBLIC** phone: Classified as public data and available to any person upon request. If this information is not provided, your application is void and will be returned to you.
- **MAILING** address: Used to send all Board correspondence. If a mailing address different than the public address is not designated, all correspondence will be sent to the public address.
- **PRIMARY** phone: If not specified, the public phone will be designated as the primary phone.

PUBLIC ADDRESS *(required)*:				TYPE *(check one)*: ☐ Home ☐ Business ☐ Other
CITY:	COUNTY:	STATE:	ZIP CODE:	

MAILING ADDRESS *(optional, provide if DIFFERENT than public address)*:				TYPE *(check one)*: ☐ Home ☐ Business ☐ Other
CITY:	COUNTY:	STATE:	ZIP CODE:	

PUBLIC PHONE *(required)*:	TYPE *(check one)*: ☐ Business ☐ Home ☐ Mobile ☐ Fax ☐ Other
PRIMARY PHONE *(optional, provide if DIFFERENT than public phone)*:	TYPE *(check one)*: ☐ Business ☐ Home ☐ Mobile ☐ Fax ☐ Other
EMAIL ADDRESS *(optional, classified as public data)*:	

LICENSEE/SUPERVISEE EMPLOYMENT INFORMATION

- If you have more than one social work position, submit a **separate** Supervision Plan form for **each position**.

EMPLOYER NAME *(no acronyms)*:			
POSITION:	START DATE: *(mm/dd/yyyy)*	END DATE: *(mm/dd/yyyy)*	

TYPE *(check one)*: ☐ Home ☐ Business ☐ Other	STREET ADDRESS:			
	CITY:	COUNTY:	STATE:	ZIP CODE:

SUPERVISION START DATE: *(mm/dd/yyyy)*	AVERAGE NUMBER OF HOURS WORKED PER WEEK:

ATTESTATION OF LICENSEE/SUPERVISEE

1. I attest that I have read, understand, and agree to comply with the supervised practice requirements for licensure under Minnesota Statutes sections 148E.100 through 148E.125.
2. I attest that this plan will be carried out as described.
3. I understand my licensing supervisor must complete the 'Supervisor' section(s) before submitting the complete form to the Board office.

SIGNATURE OF LICENSEE:	DATE:

LICENSEE/SUPERVISEE NAME & LICENSE NUMBER: _____

• SUPERVISOR #: _____ •

Supervisor must complete this section. **KEEP ALL PAGES OF THIS FORM TOGETHER.** Incomplete forms are void and will be returned.
You may make copies of this page as needed to document additional supervisors.

SUPERVISOR INFORMATION

• If you hold a social work license in another state or are licensed by another Board in Minnesota, attach copy of current license.

LAST NAME:	FIRST NAME:	MIDDLE NAME:
PHONE NUMBER:	EMAIL ADDRESS:	

HIGHEST DEGREE:	MAJOR:	DATE DEGREE CONFERRED:	COLLEGE OR UNIVERSITY:

LICENSE NUMBER:	LICENSE TYPE:	STATE:	EFFECTIVE DATE:

SUPERVISION PLAN HOURS PER MONTH

• Report number and type of hours provided per month below.
• Group supervision is limited to 6 supervisees.
• For complete information regarding the clinical supervised practice requirements, reference the Board's website.

ONE-ON-ONE SUPERVISION (hours per month)	**OTHER SUPERVISION (hours per month)**
IN-PERSON:	ONE-TO-ONE PHONE:
EYE-TO-EYE ELECTRONIC MEDIA:	GROUP:
SUPERVISION START DATE: *(mm/dd/yyyy)*	**TOTAL SUPERVISION HOURS PER MONTH:**

CERTIFICATION OF SUPERVISOR

• If you answer "NO" to any question below, include a detailed explanation (attach additional sheets if necessary).

1. I attest that I have read, understand, and agree to comply with the supervised practice requirements for licensure under Minnesota Statutes sections 148E.100 through 148E.125	**YES**	**NO**	
2. I attest that this plan will be carried out as described.	**YES**	**NO**	
3. I attest that the content of the supervision will include clinical practice, ethical standards of practice, practice methods, authorized scope of practice, and continuing competence.	**YES**	**NO**	
4. I attest that the detailed description of clinical practice is accurate.	**YES**	**NO**	
5. **ONLY SUPERVISORS LICENSED AS AN LICSW IN MINNESOTA**: I attest that I have completed: (a) completed a one-time requirement of 30 hours of training in supervision, and (b) completed at least 2,000 hours of experience in authorized social work practice, including 1,000 hours of experience in clinical practice, after obtaining my LICSW license.	**YES**	**NO**	**N/A**
6. **ONLY ALTERNATE SUPERVISORS**: I attest that I am a licensed mental health professional qualified to provide supervision according to my licensing board.	**YES**	**NO**	**N/A**

ATTESTATION OF SUPERVISOR

1. I affirm: (1) I will directly supervise the licensee/applicant as outlined in this plan; (2) the information provided is true and correct to the best of my knowledge; and (3) I understand that this information will be used to evaluate the supervisee's compliance with supervised practice requirements.
2. I will submit a Supervision Verification form at the supervisee's license renewal and/or when the supervisee applied for another license category.

SIGNATURE OF SUPERVISOR:	DATE:

LICENSEE/SUPERVISEE NAME & LICENSE NUMBER: _____

CLINICAL SUPERVISION PLAN ADDENDUM

INSTRUCTIONS FOR DETAILED DESCRIPTION OF CLINICAL SOCIAL WORK PRACTICE

GENERAL INFORMATION

• ONLY FOR LGSW AND LISE LICENSEES PRACTICING CLINICAL SOCIAL WORK •

- If you are licensed as an LGSW or LISW and are practicing social work within a clinical scope, as defined in Minnesota Statutes, Chapter 148E.010, subdivision 6 (as noted below), you will be required to submit a **Detailed Description of Clinical Social Work Practice.**
- In addition, when you renew your license or when you apply for the LICSW license, your supervisor(s) must complete a **Supervision Verification** form which includes an attestation that you have "demonstrated skill through practice experience in the diagnosis, treatment, and prevention of mental and emotional disorders".

Definition of Clinical Social Work: Minnesota Statutes, Chapter 148E.010, subdivision 6: "Clinical practice" means applying professional social work knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders. Treatment includes a plan based on a differential diagnosis. Treatment may include, but is not limited to, the provision of psychotherapy to individuals, couples, families, and groups.

INSTRUCTIONS FOR DETAILED DESCRIPTION OF CLINCIAL PRACTICE

- The Detailed Description of Practice must address ***each*** of the following elements:

1. **Client population and the range of presenting issues/diagnoses**
2. **Clinical modalities commonly utilized**
3. **Diagnostic process, including:**
   a) process utilized for determining clinical diagnoses;
   b) diagnostic instruments use, and;
   c) role of the licensee/applicant in the diagnostic process.

- It is important to be as specific and detailed as possible.
- **ALL licensing supervisors must attest to the accuracy of the detailed description of practice by providing signature and date**.
- When submitting verification of supervision, do not resubmit a detailed description of practice which has been previously submitted with a Clinical Supervision Plan.