MINNESOTA
BOARD OF SOCIAL WORK

335 Randolph Ave Ste 245
Saint Paul MN 55102
612-617-2100 | fax 651-215-0956
social.work@state.mn.us | mn.gov/boards/social-work

An Equal Opportunity Employer

Protecting the Public

PROVISIONAL LICENSE SIX-MONTH EVALUATION

• INFORMATION AND INSTRUCTIONS •

Submit Provisional License Six-Month Evaluation forms using 'ONLINE SERVICES' or 'DOWNLOADABLE FORMS' on the Board website.

- **REVIEW BOARD STATUTE:** Review supervised practice requirements on the Board of Social Work Website
- **EVALUATION REQUIRED:** Each of your supervisor(s) must complete and submit a separate Provisional License Evaluation form every six months while practicing under a provisional license, and at completion of 2000 hours of supervised practice form.
- **COMPLETE FORM:** Complete and ***KEEP ALL PAGES TOGETHER***. Submit the form(s) directly to the Board via mail or email social.work@state.mn.us. Incomplete forms will be returned and will result in delayed processing.

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;

(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 •

LICENSE NUMBER:

CURRENT LICENSE: *(check one)*

☐ Provisional LSW

☐ Provisional LGSW CLINICAL practice

☐ Provisional LGSW NONCLINICAL practice

☐ Provisional LISW CLINICAL practice

☐ Provisional LISW NONCLINICAL practice

☐ Provisional LICSW

LAST NAME: *(as it appears on license)*	FIRST NAME:	MIDDLE NAME:

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

• EMPLOYMENT INFORMATION •

If you have more than one social work position, submit a ***separate*** Six-Month Evaluation form for each position.

EMPLOYER NAME: *(no acronyms)*			
POSITION:	START DATE: *(mm/dd/yyyy)*	END DATE: *(mm/dd/yyyy)*	
STREET ADDRESS:			TYPE: *(check one)* ☐ Home ☐ Business ☐ Other
CITY:	COUNTY:	STATE:	ZIP CODE:
AVERAGE HOURS WORKED PER WEEK:	SUPERVISION START DATE:		

• LICENSEE ATTESTATION •

All licensees must check the following boxes:

☐ I attest that I have read, understand and agree to comply with the supervised practice requirements for licensure under Minnesota Statute section 148E.

☐ I will notify my supervisor(s) to complete their portion of this Six-Month Evaluation. This evaluation cannot be reviewed by the Board until all supervisor sections are completed.

LICENSEE SIGNATURE:	**DATE:**

• SUPERVISOR INFORMATION •

Supervisor must complete this section. ***KEEP ALL PAGES OF THIS FORM TOGETHER***. Incomplete forms are void and will be returned.

LAST NAME:	FIRST NAME:	MIDDLE NAME:
PHONE NUMBER:	E-MAIL ADDRESS:	

HIGHEST DEGREE:	MAJOR:	DATE DEGREE CONFERRED:	COLLEGE OR UNIVERSITY:
LICENSE NUMBER:	LICENSE TYPE:	STATE:	EFFECTIVE DATE:

• SUPERVISION HOURS PER MONTH •

- Report number and type of hours provided per month below.
- Only report supervision dates not previously reported to the Board for this position.
- Group supervision is limited to 6 supervisees.
- For complete information regarding the provisional supervised practice requirements, reference the Board's website.

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

• SUPERVISOR EVALUATION •

Supervisor must review and respond:

- Select YES or NO. Provide an explanation, if the answer is NO. The document will not be reviewed if it does not contain details for improvement when NO is selected.

YES	NO	
☐	☐	1) The licensee is making satisfactory progress in their practice related to the development of professional social work knowledge, skills, and values? If No, Explain:
☐	☐	2) The licensee is making satisfactory progress related to social work practice methods. If No, Explain:
☐	☐	3) The licensee is making satisfactory progress in their practice related to his/her authorized scope of practice. If No, Explain:
☐	☐	4) The licensee is making satisfactory progress in their practice related to ensuring continuing competence. If No, Explain:
☐	☐	5) The licensee is making satisfactory progress practice related to the ethical standards of practice. If No, Explain:

SUPERVISOR SIGNATURE:	**DATE:**

LICENSEE/SUPERVISEE NAME: _____ **LICENSE NUMBER:** _____

• SUPERVISOR CERTIFICATION •

Supervisor must review and respond:

- Select YES or NO. Provide an explanation, if the answer is NO. The document will not be reviewed if it does not contain details for improvement when NO is selected.

YES	NO	
☐	☐	1) Do you attest that the supervisee has met or has made progress on meeting the applicable supervised practice requirements? If No, Explain:
☐	☐	2) Do you declare that the supervisee has not engaged in conduct in violation of the Standards of Practice specified in the Board's Statute Chapter 148E, sections 148E.195 to 148E.240. If No, Explain:
☐	☐	3) Do you declare that the supervisee has practiced competently and ethically according to professional social work knowledge, skills, and values. If No, Explain:

SUPERVISOR SIGNATURE:	**DATE:**

• SUPERVISOR ATTESTATION •

This section must be completed by the supervisor and signed.

☐ I attest this supervised practice has been carried out in compliance with Minnesota Statues 148E.

☐ I also affirm that the information I have provided is true and correct to the best of my knowledge. I understand that this information will be used to evaluate the supervisee's compliance with requirements for licensure as a social worker.

SUPERVISOR SIGNATURE:	**DATE:**

SUPERVISOR:

- **PLEASE RETURN THE ORIGINAL FORM DIRECTLY TO THE BOARD OF SOCIAL WORK:**
  BY EMAIL TO:
  social.work@state.mn.us
  OR
  BY MAIL TO:
  335 RANDOLPH AVE, SUITE 245
  SAINT PAUL, MN 55102
- **PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.**
- **IF THE BOARD NEEDS ADDITIONAL INFORMATION, YOU WILL BE CONTACTED.**

LICENSEE/SUPERVISEE NAME: _____ **LICENSE NUMBER:** _____