MINNESOTA
BOARD OF SOCIAL WORK

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An Equal Opportunity Employer

Protecting the Public

PROVISIONAL LICENSE NON-CLINICAL SUPERVISION PLAN

• INFORMATION AND INSTRUCTIONS •

Submit 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 and MN Statute 148E.
- **SUPERVISION PLAN REQUIRED:** Provisional Supervision Plans must be submitted to the Board within **30 days** of beginning a social work position. Submit:
  (1) revised plan within 30 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.*** 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.
- **EVALUATION REQUIRED:** Provisional License Evaluation forms are due every six months while practicing under a provisional license, and at completion of 2000 hours of supervised practice.

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 •

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

☐ **INITIAL PLAN**	☐ **REVISED PLAN**	☐ New supervisor	☐ Additional supervisor	☐ Type or amount of supervision
		☐ Employment	☐ Scope of position	

LICENSE NUMBER:

CURRENT LICENSE: *(check one)* ☐ Provisional LSW ☐ Provisional LGSW ☐ Provisional LISW

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 document 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: *(classified as public data)*	

• EMPLOYMENT INFORMATION •

If you have more than one social work position, submit a separate Provisional License Supervision Plan 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:	

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

• 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 148E.
I attest that this plan will be carried out as described.

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

LICENSEE SIGNATURE:	**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 •
(Supervisor must complete this section.)

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 provisional license 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 BY SUPERVISOR •
(Supervisor must complete this section.)

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

YES	NO	
☐	☐	I have completed a one-time requirement of 30 hours of training in supervision *or* I am an ALTERNATE SUPERVISOR and attest I am a licensed mental health professional qualified to provide supervision according to my licensing board.
☐	☐	I affirm that this Non-Clinical Supervision Plan will be carried out as described in Minnesota Statute 148E. I further understand that a revised Supervision Plan form must be submitted within 30 days of changes outlined in Minnesota Statute Chapter 148E.
☐	☐	I attest that the content of the supervision will include ethical standards of practice, practice methods, authorized scope of practice, and continuing competence.
☐	☐	I attest I will submit a Provisional License Evaluation form every six months and a Provisional License Final Evaluation form after completion of the 2,000 hours of supervised practice and 37.5 supervision hours, while providing supervision for practice under a provisional license, demonstrating that the supervisee has met or has made progress on meeting the applicable supervised practice requirements as outlined in Minnesota Statute, Chapter 148E.

SUPERVISOR SIGNATURE:	**DATE:**

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