MINNESOTA
BOARD OF SOCIAL WORK

An Equal Opportunity Employer

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

Protecting the Public

PROVISIONAL LICENSE FINAL EVALUATION

▪ INSTRUCTIONS TO COMPLETE THIS FORM ▪

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK AND KEEP ALL PAGES OF THIS FORM TOGETHER.

☑ Each of your supervisor(s) must complete and submit a separate form. This form may be duplicated.
☑ Attach a job description to this form, which corresponds to the position being documented.
☑ The Provisional Licensee must complete and sign page 1 of the form.
☑ Then submit the ***entire form*** to your supervisor for completion of pages 2, 3 and 4. Your supervisor must submit all pages of this form directly to the Board.

▪ PROVISIONAL LICENSEE INFORMATION ▪
(Licensee must complete this section.)

▪HAVE YOU PREVIOUSLY SUBMITTED A SUPERVISION PLAN FOR THE SUPERVISED PRACTICE REPORTED ON THIS FORM? *(circle)* **▪ YES** **▪ NO**

LICENSE NUMBER:	LICENSE HELD : *(circle)*	LSW	LGSW clinical scope LGSW non-clinical scope	LISW clinical scope LISW non-clinical scope	LICSW

FULL LEGAL NAME: LAST NAME	FIRST NAME:	MIDDLE NAME:
PROFESSIONAL NAME: LAST NAME (If different from legal name)	FIRST NAME:	MIDDLE NAME:

MAILING ADDRESS: (NEW circle: YES NO)		E-MAIL ADDRESS:	
CITY:	COUNTY:	STATE:	ZIP CODE:
DAYTIME PUBLIC TELEPHONE:		FAX:	

▪ PROVISIONAL LICENSEE POSITION INFORMATION SUBMITTED FOR CONSIDERATION ▪

AGENCY/EMPLOYER NAME FOR POSITION REPORTED ON THIS FORM (may be different from current employment):

AGENCY ADDRESS:

CITY:	COUNTY:	STATE:	ZIP CODE:

PROVISIONAL LICENSEE'S POSITION TITLE:

▪RECORD FULL-TIME & PART-TIME PRACTICE DATES & NUMBER OF PART-TIME HOURS PER WEEK FOR THE POSITION REPORTED.

▪ FULL-TIME ▪	FROM: (mo/yr)	TO: (mo/yr)	
▪ PART-TIME ▪	FROM: (mo/yr)	TO: (mo/yr)	NUMBER OF HOURS PER WEEK:

PROVISIONAL LICENSEE SIGNATURE:	**DATE:**

▪ SUPERVISOR SECTION INSTRUCTIONS ▪

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK AND KEEP ALL PAGES OF THIS FORM TOGETHER.

All Supervisors:

☑ Complete pages 2, 3 and 4, and provide your signature on page 4. Please keep a copy for your records.
☑ Review the attached position description.
☑ Submit all pages of this form directly to the Board office at the address listed on the form.

▪ SUPERVISOR INFORMATION ▪

(**Supervisor must complete this section.)**

LAST NAME:	FIRST NAME:	MIDDLE NAME:
MAILING ADDRESS:		
CITY:	STATE:	ZIP CODE:
LICENSE NUMBER: (identify if other than Minnesota)	EFFECTIVE DATE OF CURRENT LICENSE:	CATEGORY OF LICENSURE:
HIGHEST DEGREE:	MAJOR:	DATE DEGREE CONFERRED: / COLLEGE OR UNIVERSITY:
PRESENT EMPLOYER:	EMAIL ADDRESS:	
ADDRESS:	DAYTIME PUBLIC TELEPHONE:	
CITY:	STATE:	ZIP CODE:
TITLE AT TIME OF SUPERVISION:	OTHER BOARD LICENSURE:	

▪ SUPERVISOR'S REPORT OF SUPERVISION PROVIDED ▪

Dates of supervision:	FROM: (mo/yr)	TO: (mo/yr)

List average number of hours for each type of supervision provided per month below:

▪ In-person one-on-one supervision: _____
▪ In-person group supervision: _____
▪ Number of members in group: _____
▪ Electronic supervision: _____

NOTE: In-person one-on-one supervision must be ½ of the required hours.
In-person group supervision may not exceed more than ½ of the required hours.
Electronic supervision may not exceed more than 1/3 of the required hours.
Group supervision may not exceed 7 members, including licensed social work supervisor.

PROVISIONAL LICENSEE NAME & LICENSE NUMBER: _____

▪ SUPERVISOR'S EVALUATION OF PROVISIONAL LICENSEE'S PRACTICE ▪ **(Supervisor must complete this section by 1) circling a response, and 2) providing explanation to each question.)**		
Requirements Met	Requirements **Not** Met	1) Please evaluate the licensee's practice related to the development of professional social work knowledge, skills, and values. _____ _____ _____ _____
Requirements Met	Requirements **Not** Met	2) Please evaluate the licensee's practice related to social work practice methods. _____ _____ _____ _____
Requirements Met	Requirements **Not** Met	3) Please evaluate the licensee's practice related to his/her authorized scope of practice. _____ _____ _____ _____
Requirements Met	Requirements **Not** Met	4) Please evaluate the licensee's practice related to ensuring continuing competence. _____ _____ _____ _____
Requirements Met	Requirements **Not** Met	5) Please evaluate the licensee's practice related to ethical standards of practice. _____ _____ _____ _____
Requirements Met	Requirements **Not** Met	6) If applicable, please evaluate the licensee's practice related to clinical practice. _____ _____ _____ _____

PROVISIONAL LICENSEE NAME & LICENSE NUMBER: _____

▪ SUPERVISOR'S DECLARATION ▪ (Supervisor must complete this section by circling appropriate response and providing evaluation.)		
Yes	No	Do you affirm that the supervision provided for the position documented using this form was carried out as described previously in the Supervision Plan considered and approved by the Board?
Yes	No	Is the position description which the provisional licensee has attached to this form an accurate reflection of the licensee/applicant's practice? If the response is "no", please attach an explanation.
Yes	No	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 148D, sections 148D.195 to 148D.240? If the response is "no", please attach an explanation.
Yes	No	As part of this final evaluation, do you attest to the supervisee's ability to engage in the practice of social work safely and competently? Please provide an evaluation below.

Affirmation: I hereby affirm that I directly supervised the named licensee and affirm that the licensee has met the applicable provisional license supervised practice requirements. I 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 licensee's compliance with provisional license requirements and eligibility for a permanent license as a social worker.

SUPERVISOR NAME: ***(please print)***	**LICENSE CATEGORY & NUMBER:**
SUPERVISOR SIGNATURE:	**DATE:**

Classification of Data: Information which you and your supervisor provide on this form is classified as private data prior to licensure and is accessible only to you, Board members and staff, the Board's legal counsel, and persons whom you designate. When your application is approved, the information provided on this form and all other information related to your supervision verification will be classified as public data. Public data is available to any person upon request. The purpose and intended use of this information is to enable the Board to determine whether the documented supervised practice meets statutory requirements for licensure. You are not legally required to provide this information, but the Board will not be able to take action without this information.

SUPERVISOR:

- **PLEASE RETURN THE ORIGINAL FORM DIRECTLY TO THE BOARD ADDRESS LISTED ON THE FIRST PAGE.**
- **PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.**
- **IF THE BOARD NEEDS ADDITIONAL INFORMATION, YOU WILL BE CONTACTED.**

PROVISIONAL LICENSEE NAME & LICENSE NUMBER: _____