



## 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	LISW clinical scope	LICSW
			LGSW non-clinical scope	LISW non-clinical scope	
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:
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**▪ 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)
<p><b>List average <u>number of hours</u> for each type of supervision provided <u>per month</u> below:</b></p> <p> <input type="checkbox"/> In-person one-on-one supervision: _____                  <input type="checkbox"/> In-person group supervision: _____                  <input type="checkbox"/> Electronic supervision: _____  <input type="checkbox"/> Number of members in group: _____         </p>		
<p><b>NOTE:</b> 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.</p>		

**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 <b>Not Met</b>	<p>1) Please evaluate the licensee's practice related to the development of professional social work knowledge, skills, and values.</p> <hr/> <hr/> <hr/> <hr/>
Requirements Met	Requirements <b>Not Met</b>	<p>2) Please evaluate the licensee's practice related to social work practice methods.</p> <hr/> <hr/> <hr/> <hr/>
Requirements Met	Requirements <b>Not Met</b>	<p>3) Please evaluate the licensee's practice related to his/her authorized scope of practice.</p> <hr/> <hr/> <hr/> <hr/>
Requirements Met	Requirements <b>Not Met</b>	<p>4) Please evaluate the licensee's practice related to ensuring continuing competence.</p> <hr/> <hr/> <hr/> <hr/>
Requirements Met	Requirements <b>Not Met</b>	<p>5) Please evaluate the licensee's practice related to ethical standards of practice.</p> <hr/> <hr/> <hr/> <hr/>
Requirements Met	Requirements <b>Not Met</b>	<p>6) If applicable, please evaluate the licensee's practice related to clinical practice.</p> <hr/> <hr/> <hr/> <hr/>

**PROVISIONAL LICENSEE NAME & LICENSE NUMBER:** \_\_\_\_\_

