MINNESOTA
BOARD OF SOCIAL WORK

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An Equal Opportunity Employer

Protecting the Public

NONCLINICAL 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
- **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** *(check change)*	☐ New supervisor	☐ Additional supervisor	☐ Type or amount of Supervision
		☐ Employment	☐ Scope of position	

LICENSE NUMBER:	CURRENT LICENSE *(check one)* ☐ **LSW** ☐ **LGSW not engaged in clinical social work practice**

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)*:	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)*	

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)*

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:

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 nonclinical 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 ethical standards of practice, practice methods, authorized scope of practice, and continuing competence.	☐ YES	☐ NO	
4. **ONLY SUPERVISORS LICENSED AS SOCIAL WORKERS IN MINNESOTA**: I attest that I have completed a one-time requirement of 30 hours of training in supervision.	☐ YES	☐ NO	☐ N/A
5. **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: _____