



# NORTH CAROLINA SOCIAL WORK CERTIFICATION AND LICENSURE BOARD

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## EMPLOYMENT VERIFICATION For LCSWA

### INSTRUCTIONS TO COMPLETE THIS FORM

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

1. A *separate form must be completed for each place of employment*. This form may be duplicated.
2. **Attach a job description** on company letterhead to this form, which corresponds to each position being documented.
3. Complete section I. Then submit the *entire form* to your employer for completion of Section II & signature.

### SECTION I: LCSWA LICENSEE INFORMATION

(To be completed by the LCSWA)

Pursuant to the Social Worker Certification and Licensure Act [NCGS § 90B-15] your license shall be conspicuously displayed at your primary place of practice. Please verify your issue date and expiration date below.

LAST NAME:	FIRST NAME:	MIDDLE NAME:
LICENSE #:	ISSUE DATE:	EXPIRATION DATE:
MAILING ADDRESS: (NEW? circle YES NO )	EMAIL ADDRESS	DAYTIME PHONE:
CITY	STATE	ZIP CODE

### SECTION II: TO BE COMPLETED BY THE EMPLOYER

AGENCY NAME - FOR POSITION REPORTED ON THIS FORM:		
AGENCY ADDRESS:		
CITY:	STATE:	ZIP CODE
LICENSEE/APPLICANT'S POSITION TITLE: (position job description MUST be attached)		
IN THIS POSITION, IS THE LICENSEE AUTHORIZED TO PROVIDE CLINICAL SERVICES? (circle one)      YES      NO		
NAME OF LICENSEE/APPLICANT'S <u>LCSW</u> CLINICAL SUPERVISOR:		SUPERVISOR LOCATED: (circle one)
LCSW #	ON SITE	OFF SITE

Is the social worker being paid a fee or salary?  YES  NO

Please identify type of employment below:

FULL-TIME	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)
PART-TIME	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)
PRN	FROM: (mm/dd/yyyy)	TO: (mm/dd/yyyy)

PRINT NAME & TITLE OF PERSON COMPLETING EMPLOYER SECTION:	SIGNATURE:	DATE:
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