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 **CURRENT** 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 ***LCSW*** **CLINICAL** SUPERVISOR:	SUPERVISOR LOCATED: (circle one)	
LCSW #:	ON SITE	OFF SITE

Is the social worker being paid a fee or salary? □ YES □ NO Identify type & beginning date of **CURRENT** position 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: