



NORTH CAROLINA
SOCIAL WORK CERTIFICATION AND LICENSURE BOARD

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Employer Verification Form

(Top portion to be completed by applicant)

Applicant Name _____ Date _____

Employer Name (Print): _____

Check one:

_____ **Licensed Clinical Social Worker or Provisional-Licensed Clinical Social Worker (level C):** Verify total number of hours and dates of paid supervised post-MSW practice in a clinical setting. (Requires accompanying Clinical Social Work Supervision form reflecting the same time frame)

_____ **Certified Social Work Manager (level H):** Verify total number of hours and dates of paid supervised employment in an administrative social work position. (Requires accompanying CMSW Supervision form reflecting the same time frame)

TO BE COMPLETED BY THE EMPLOYER

The above named individual is applying for social work certification/licensure. Your input and candor in completing this form would be appreciated. Please print legibly or type all answers. Carefully answer each question. Please return this form to the applicant in an envelope with your signature over the sealed closure. He or she will in turn forward your sealed envelope to us with the completed application packet. You may also feel free to write or call the Board directly if you have any special concerns.

1. What was the title of the applicant's position? _____

2. Place of Employment: _____

3. Applicant's supervisor: _____ (Name) _____ (Title)

4. What were the applicant's specific duties? _____

5. When was applicant employed? From (MM/DD/YYYY): _____ to (MM/DD/YYYY): _____
Was the employee fulltime _____ or part-time _____? Total hours employed during period: _____

My knowledge in this matter is based on: _____ personnel records _____ personal experience with applicant

Signed _____ Date _____

Name _____ Title _____

Address _____

City _____ State _____ Zip _____

Phone(s) _____

Please return this form to the applicant in an envelope with your signature over the sealed closure.
Thank you for your assistance with this application.