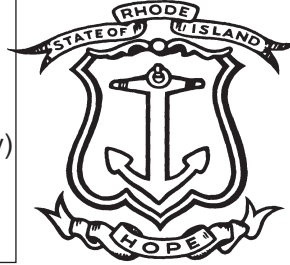


\*\*\*FOR OFFICE USE ONLY\*\*\*

**Social Worker Checklist**

- Endorsement       Examination
- App. & Fee
- Date: \_\_\_\_\_ Check \_\_\_\_\_
- Photo ID
- Transcript
- Exam Results from ASWB (For LICSW Only)
- Lic. Verification from other States
- Supervised Practice Forms (LICSW)



\*\*\*FOR OFFICE USE ONLY\*\*\*

Application Approved:
License Number:
Issue Date:
Approved for ASWB
Signature of Board Administrator
Board Member Signatures
ID#:
Receipt #:

**Rhode Island  
Board of Social Work Examiners**

Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and Application For  
License As A***

- Licensed Clinical Social Worker (LCSW)
- Licensed Independent Clinical Social Worker (LICSW) - (Clinical Exam)

- Endorsement**
- Examination**

<b>MILITARY STATUS ELIGIBILITY</b>	<i>(Documentation Required) see next page for instructions</i>
Please check ONE of the following criteria for expedited application:	
<input type="checkbox"/> I am in active military duty or a reservist	
<input type="checkbox"/> I am a military veteran with honorable discharge	
<input type="checkbox"/> I am the spouse of someone in active military duty or the spouse of a reservist	

*Applicant - Print Name*

--	--	--

*LAST NAME*

*FIRST NAME*

*MI*

**Phone: (401) 222-2828**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-1272**

# LICENSURE REQUIREMENTS

---

- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$70.00** and attached to the upper left-hand corner of the first (Top) page of the application. **THIS APPLICATION FEE IS NONREFUNDABLE.**
- Copy of Valid ID, (example Driver's license or state issued ID)
- Official transcript from an accredited School of Social Work submitted by the college/school/university, directly to the Board. Transcript must include date of completion, graduation date and degree.  
No student copies will be accepted.
- If you are applying for Independent Clinical Social Worker (LCSW) Only - Exam Score/Certification sent directly from the Association of Social Work Boards (ASWB) (**Telephone 1-888-579-3926**) (NOTE: Successful completion of the ASWB examination IS required to obtain a license to practice as an independent social worker in the state of Rhode Island).
- It is important to note that, per Rhode Island General Laws Chapter 5-39.1-8, License Procedure for Social Workers, there is NO exam required for a Licensed Clinical Social Worker (LCSW) license until at least August 15, 2025.**
- If you are applying for LCSW Only - Completed Supervised Practice Form included with this application to be used for that purpose must be submitted directly to the Board in sealed envelope
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose) The Verification Form from the State of original licensure must include test scores for independent clinical social worker only, of the ASWB examination (or test scores may be sent directly from ASWB). If test scores are provided, you do not need to contact the ASWB to request the test scores. In addition to test scores, if the Supervised Practice Prerequisite is provided by the Endorsement State(s), then you are not required to submit the Supervised Practice Forms.
- If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

## Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

## License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



# State of Rhode Island and Providence Plantations Board of Social Work Examiners

Application for License as a Licensed Clinical Social Worker or Licensed Independent Clinical Social Worker

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

## 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

**NOTE:**  
It is your responsibility to notify the Department of Health Board of any name changes.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden Name, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

## 2. Social Security Number

 -  - 

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."**

## 3. Gender

 Male Female

## 4. Date of Birth

 /  / 

Month

Day

Year

## 5. Home Address

It is your responsibility to notify the board of all address changes.

No professional licensee's address (residence or business/employment) will be posted on the Department's Web site.

1st Line Address (Apartment/Suite/Room Number, etc.)

2nd Line Address (Number and Street)

City

State

 - 

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 - 

Home Phone

 - 

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

## 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

**This address will appear on the Department of Health web site.**

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

 - 

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 - 

Business Phone

Extension

 - 

Business Fax



**11. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?

Yes  No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Month	Year
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**12. Disciplinary Questions**

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending?

Yes  No

2. Have you ever been denied a license, certificate, registration or permit in any state?

Yes  No

**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

**13. Affidavit of Applicant**

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Licensed Clinical Social Worker/Licensed Independent Clinical Social Worker in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Social Work Examiners of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant \_\_\_\_\_

Date of Signature (MM/DD/YY) \_\_\_\_\_



Substitute forms are not acceptable, One (1) form is required for each state in which you hold, or have held a license.

# Rhode Island Board of Social Work Examiners

Copy this form as needed.

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for a license to practice as a Licensed Clinical Social Worker/Licensed Independent Clinical Social Worker in the State of Rhode Island. The Rhode Island Board of Social Work Examiners requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Social Work Examiners at the above address.

Print/Type Full Name _____	Signature _____	Date _____
Previous Names Used _____	Social Security Number _____	Date of Birth _____
License Number _____	Date Issued _____	

### THIS SECTION TO BE COMPLETED BY THE SOCIAL WORK BOARD

**Directions for State Board:** Please complete and return this form to the address above with copies of any verification of supervision received\* after the applicant received their MSW. *Please verify requirements met in your state:*

MSW from CSWE Accredited School? <input type="checkbox"/> Yes <input type="checkbox"/> No	Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not by examination, how was license obtained? Endorsement _____ (State) Other _____ (Ex-plain)
Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No Score _____ Level of Exam: _____	License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued: _____ Expiration Date: _____

\*Two years post-MSW supervised experience?  
 Yes  No If YES, please indicate the total number of required post-MSW supervised hours: \_\_\_\_\_

**Questions:**

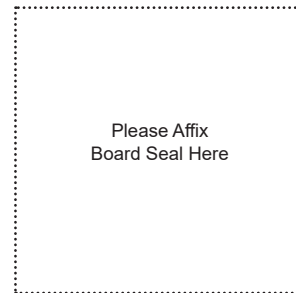
- Has this licensee ever been investigated by your Board?  Yes  No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
- Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Certification:

Signature _____	Date _____
Type or Print Name _____	
Title _____	
Full Name of Licensing Board _____	



Please return directly to the Board at the above address. Thank you for your prompt cooperation.



# Rhode Island Board of Social Work Examiners

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## SECTION I - SUPERVISED PRACTICE FORM - CERTIFICATION OF EXPERIENCE

The individual named below is applying for certification as a Licensed Independent Social Worker in the State of Rhode Island. Prior to certifying the applicant, it is necessary to verify his/her past clinical supervision and/or clinical experience while supervised by you. The applicant has completed Section I and is requesting that you complete Section II. By signing below, the applicant attests that the information is correct to the best of his/her knowledge.

Print/Type Full Name _____	Signature _____	Date _____
Previous Names Used _____	Social Security Number _____	Date of Birth _____
Dates of Clinical Experience under supervision of the practitioner completing Section II. FROM: _____ TO: _____	Month Day Year	Month Day Year
Description of Applicant's Primary Responsibilities and position: _____	Number of Hours Worked per Week _____	Number of Direct Client Contact Hours per Week _____

**INSTRUCTIONS TO APPLICANT:** If you have had more than one supervisor, and evidence is needed from two or more supervisors to document the minimum level of supervised clinical experience required for Licensure, the applicant must complete Section I on each form forwarded to the individual supervisors. It is the responsibility of the applicant to gather all forms completed by supervisors in sealed envelopes with supervisor's signature across the back flap (seal) and mail in one packet to the Rhode Island Board of Social Work Examiners.

**EXPERIENCE REQUIREMENTS FOR LICSW:** Chapter 5-39.1 of the General Laws of the State of Rhode Island establishes experience requirements which must be met prior to application for the Independent Clinical Social Work License. These requirements became effective on July 1, 1994. Experience is defined as three thousand (3,000) hours of post-master's practice of clinical social work during a twenty-four (24) to seventy-two (72) month period of time immediately preceding the date of application for LICSW. One thousand five hundred (1,500) hours must consist of providing clinical social work services directly to clients. Clinical social work practice is defined as the professional application of social work theories, methods, and values in the diagnosis, assessment, and treatment of cognitive, affective and behavioral disorders arising from physical, environmental, or emotional conditions. Clinical social work services also include psychotherapy and counseling for individuals, couples, families, and groups; client-centered advocacy; consultation and supervision. NOTE: The experience must occur DURING A 24-72 MONTH PERIOD of time immediately preceding the date of the application for licensure (2 YEAR MINIMUM, 6 YEAR MAXIMUM).

Supervision is defined as face-to-face contact with a licensed independent social worker (LICSW) for the purpose of apprising the supervisor of the diagnosis, assessment, and treatment of each client; receiving oversight and guidance from the supervisor in the delivery of clinical social work services to each client; and being evaluated by the supervisor.

- 1.) A minimum of two (2) hours of supervision every two (2) weeks.
- 2.) A minimum of one (1) hour of supervision per twenty (20) hours of direct contact with clients.
- 3.) One-to-one (Individual Supervision) contact with the supervisor at least seventy-five percent (75%) of the time.
- 4.) Supervision by an individual other than the applicant's parents; spouse; former spouse; siblings; children; employees; or anyone sharing the same household or any romantic, domestic or familial relationship.

## SECTION II - THIS SECTION TO BE COMPLETED BY SUPERVISOR

**Instructions to supervisor:** Please complete Section II of this form and return to the applicant. The Rhode Island Board of Social Work Examiners requests that the supervisor carefully review the applicant's statements under Section I prior to responding to Items in Section II. Insert completed form in an envelope and seal signing your name across the seal. Return to applicant. Applicant has been instructed to include your sealed envelope in his/her application packet.

<b>Supervisor's Professional Degree, Discipline and License Information:</b>	Agency and State in which Supervision Occurred: _____ Agency _____ State _____
	Describe the nature of the Supervision: _____
	Length and frequency of Supervision: _____
	<b>Certification:</b> I hereby attest the above information in Section II is correct, to the best of my knowledge.
	Signature _____ Date _____

Type or Print Name \_\_\_\_\_ Title \_\_\_\_\_

Supervisor's Address: \_\_\_\_\_



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*