

**South Dakota Board of Social Work Examiners  
810 N. Main St., #298  
Spearfish, SD 57783**

**VALIDATION OF CONTINUING EDUCATION OBTAINED OUT OF STATE**

I. Person attending the continuing education program:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street

City

State

Zip

Present Level of Licensure \_\_\_\_\_ License Number \_\_\_\_\_

II. Sponsoring Agency \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street

City

State

Zip

Phone Number \_\_\_\_\_

III. Continuing Education Information:

Title of Agency \_\_\_\_\_

Dates: Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

Total Number of Contact Hours \_\_\_\_\_

Description of Activity:

1. Please include the goals and objectives of the program.
2. How did this course or program apply to the enhancement of social work practice, values and knowledge.
3. Please attach a copy of the program. (Agenda)\*

IV. Certification of Attendance:

I hereby certify that \_\_\_\_\_ did attend the  
(Name of Person Attending)  
above described continuing education activity.

\_\_\_\_\_  
(Signature of Program Director)

\* We must be able to compute contact hours; an agenda is crucial.