

**REQUIRED SUPERVISION VALIDATION TO MEET SOCIAL WORK ASSOCIATE LICENSING**

**\*\*PLEASE SUBMIT BY THE DEADLINE OF MARCH 15<sup>TH</sup>, 2017**

**SOUTH DAKOTA BOARD OF SOCIAL WORK EXAMINERS  
810 N. MAIN ST., SUITE 298  
SPEARFISH, SD 57783**

This section is to be completed by the Social Work Associate. Please print in blue or black ink only. Please have all your supervisors for the entire 2016 calendar year complete a form. You may duplicate this form. Return this form to the above listed address by March 15, 2017. Thank you.

Name of Associate: \_\_\_\_\_ License Number: \_\_\_\_\_  
(Last Name) (First Name)

Mailing Address: \_\_\_\_\_  
(Mailing address) (City) (State) (Zip Code)

Signature of Social Work Associate: \_\_\_\_\_

Please Check Here if **NOT** employed in the Social Work Field: \_\_\_\_\_.

**Note: We must have this form returned to the board office even if you are not working in the field of Social Work at this time. If you are not working in the field of Social Work, please fill out the above information only then sign and return the form.**

**THIS SECTION TO BE COMPLETED BY THE SUPERVISOR.** Please print in blue or black ink.  
The above named social work associate is employed by the following in the practice of social work:

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_  
(Mailing address) (City) (State) (Zip Code)

Associate has been employed from **(IN THE YEAR 2016)** \_\_\_\_\_ to \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

Employment is for approximately \_\_\_\_\_ hours per week.  
The supervision received is \_\_\_\_\_ Individual \_\_\_\_\_ Peer \_\_\_\_\_ Group \_\_\_\_\_ Other \_\_\_\_\_  
(Please check all that apply)

The length and frequency of such supervision is \_\_\_\_\_ Hours per \_\_\_\_\_ (List month or week).  
(Law requires a minimum of 4 hours per month.)

I, \_\_\_\_\_, Supervisor, hereby certify that the above employment and  
(Last Name) (First Name)  
supervision information is an accurate description of this associate's supervision. I supervised the associate  
from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
(Signature) (Date) CSW-PIP; CSW; SW; OTHER \_\_\_\_\_  
(Circle your level of licensure)

\_\_\_\_\_  
(Title) (State License Number)

The above is based on: \_\_\_\_\_ Personnel Records \_\_\_\_\_ My Own Knowledge