



**NORTH CAROLINA  
SOCIAL WORK CERTIFICATION AND LICENSURE BOARD**

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www.ncswboard.gov

**EMPLOYMENT VERIFICATION**

**For LCSWA or new Applicant with supervised clinical practice out of state  
ONLY COMPLETE THIS FORM IF YOU ARE CURRENTLY LICENSED AS A LCSWA OR ARE A NEW APPLICANT  
DOCUMENTING SUPERVISED CLINICAL PRACTICE ACCRUED OUT OF STATE**

**INSTRUCTIONS TO COMPLETE THIS FORM**

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK

1. *A separate form must be completed for each place of employment.* This form may be duplicated.
2. **ATTACH a job description on company/agency 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 OR APPLICANT INFORMATION**

(To be completed by the LCSWA or Applicant)

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 # AND STATE:	ISSUE DATE:	EXPIRATION DATE:
MAILING ADDRESS: (NEW ADDRESS <input type="checkbox"/> )	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 POSITION TITLE: (job description <b>MUST</b> be attached for this Position)		
IN THIS POSITION, IS THE LICENSEE AUTHORIZED TO PROVIDE CLINICAL SERVICES? (CIRCLE ONE) <b>YES</b> <b>NO</b>		
NAME OF LICENSEE/APPLICANT'S <u>LCSW CLINICAL</u> SUPERVISOR:		SUPERVISOR LOCATED: (circle one)
LCSW #:	ON SITE	OFF SITE
Is/Was the social worker being paid a fee or salary? <input type="checkbox"/> YES <input type="checkbox"/> NO      Identify type & beginning date of 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: