



NORTH CAROLINA
SOCIAL WORK CERTIFICATION AND LICENSURE BOARD

Post Office Box 1043
Asheboro, North Carolina 27204

Phone (336) 625-1679
Fax (336) 625-4246

www.ncswboard.gov

CLINICAL EXAM REQUEST FORM

This form is to be used once you have completed two years of clinical practice and submit to the Board for examination eligibility. **PLEASE READ THIS DOCUMENT CAREFULLY AND MAINTAIN A COPY FOR YOUR RECORDS.** You may include this form with your LCSWA renewal submission **IF** you have met two years (24 months) of clinical practice at that time. Upon receipt of this document, the Board will review all submitted six-month review forms to determine completion of two years of clinical practice. **If you have not submitted your review forms at the assigned six-month review dates as required or have not responded to requests for additional information, please note that review may be delayed. Also, please be advised that you must maintain appropriate clinical supervision until you have applied for and have been issued the LCSW license.**

Upon receipt of your payment and exam request, the Board will review your record to ensure **completion of two years of clinical experience** and once confirmed, will forward to you instructions for registering to sit for the examination including an expiration date. The exam approval is good for **ONE** exam attempt during the approval period. You will be able to register with ASWB **ONLY** after the Board has given authorization. Upon registration with ASWB you will be sent authorization and contact information for PSI Test Centers. You may then select the center of your choice and schedule directly with the testing center. Testing is generally available Monday through Saturday at most sites. A PASS/FAIL report will be presented to you at the testing site upon completion of the examination. If you have an unsuccessful examination, you may submit another request for examination to begin the process again (including submission of the processing fee).

An official score report will be sent automatically to this Board from ASWB. **We do not notify you when we receive your results from the exam board. These scores are maintained in your records.** If you have a successful examination and have completed all other requirements for the LCSW license (two years of supervised clinical practice with 3,000 clinical practice hours and 100 hours of clinical supervision), you may submit the LCSW Short Form application with all required materials and fee.

BEFORE YOU MAIL YOUR CLINICAL EXAM REQUEST

Please be advised that if your record is incomplete or is missing any required documentation, this will lead to processing delays. For any clinical practice and supervision to be considered, the following items must be received and reviewed by the Board prior to receiving exam eligibility.

___ Have you submitted an Employment Verification form with job description and Emergency Crisis Plan for each employer where you have provided clinical services while licensed as a LCSW-Associate?

___ Have you submitted a Position Statement for each clinical supervisor that has provided your clinical supervision while licensed as a LCSW-Associate?

___ Have you submitted six-month review forms to document completion of two years of supervised clinical practice? (Including the review form submitted with this request)

If you are unsure that any of the documentation listed above may be missing from your record, please send a copy with your exam eligibility request to ensure receipt.

Mail completed document(s) with the \$40 certified check or money order to:

**NCSWCLB
PO BOX 1043
ASHEBORO NC 27204**

Is this your first attempt at the ASWB Clinical Exam? Yes No

Mark all boxes below, complete and sign with Clinical Supervisor.

- Completed **two years (24 months) of clinical practice**. Indicate first date of clinical practice: ____/____/____
- Attached Six-Month Review (must be included to demonstrate completion of two years' experience).
- Enclosed Exam Processing Fee of \$40.00 by certified check, money order, or cashier's check submitted within six months of issuance. *(No personal checks accepted). THE PROCESSING FEE DOES NOT INCLUDE THE COST OF THE EXAMINATION (Paid directly to ASWB).*

NAME: _____
(As it appears on your form of ID)

LICENSE #: _____

Address: _____

DOB: ____/____/____

Email Address: _____

LCSWA SIGNATURE: _____

I affirm that the above named individual has, to the best of my knowledge, **completed two years of clinical practice** and qualifies to take the ASWB Clinical exam at this time.

CLINICAL SUPERVISOR NAME: _____ LICENSE #: _____

CLINICAL SUPERVISOR SIGNATURE: _____