

State of Utah  
Department of Commerce  
Division of Occupational and Professional Licensing

**Certified Social Worker**

**APPLICANT INFORMATION**

Full Legal Name: \_\_\_\_\_  
*First Middle Last*

All Previous Legal Names: \_\_\_\_\_

Other DOPL Licenses Held: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_  
*Street Address (including Apt/Unit/Ste #) and/or PO Box*

\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Please Select ONE:**

- I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: \_\_\_\_\_

**Driver License  
or State ID Card**

\_\_\_\_\_  
*State of Issue License Number Expiration Date*

**NOTE:** If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

**AFFIDAVIT AND RELEASE**

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

## QUALIFYING QUESTIONNAIRE

### Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1.  Yes  No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2.  Yes  No Do you CURRENTLY have **any criminal action active or pending**?

3.  Yes  No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **misdemeanor** in any jurisdiction?

4.  Yes  No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2,3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- court record(s)
- police report(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

#### NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's [criminal history FAQs](#).

## PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. (Use additional sheets if necessary.)

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

If you identified a certified social worker license above, please answer the following:

Yes  No After obtaining the license(s) above, have you engaged in at least one year of experience in the state, district, or territory of the United States where the license was issued?

Note: If you answer yes to the question above, please see the checklist at the end of this application or [our website](#) for instructions on applying by endorsement.

## MEDICAL QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer each question. Do not leave any question blank.**

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:
- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_
2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:
- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_
3. Is any action pending against you now by:
- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_
4.  Yes  No Have you been named as a defendant in a malpractice suit?
5.  Yes  No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. NPDB website: <http://www.npdb.hrsa.gov>.

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

## EXAM REQUIREMENTS

**Select one:**

- I have passed the ASWB Masters Exam for Utah.
- I have passed the ASWB Clinical Exam for Utah
- I have passed either the ASWB Masters or Clinical Exam in another state.

**State:** \_\_\_\_\_ **Exam Date:** \_\_\_\_\_

# Verification of Active Practice as an CSW

For endorsement applicants applying by via Option 2. See checklist for additional information  
Applicants using [Option 1](#) do not need to complete this form.  
Each employer must complete a separate form.

## APPLICANT INFORMATION

To be completed by the applicant.

**Full Legal Name:** \_\_\_\_\_  
*First Middle Last*

**Mailing Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

**License Number:** \_\_\_\_\_ **State of Issue:** \_\_\_\_\_

## EMPLOYMENT INFORMATION

To be completed by the Employer or Human Resources.

**Name of Establishment:** \_\_\_\_\_

**Establishment Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

**Telephone Number** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Dates of Employment:** \_\_\_\_\_ to \_\_\_\_\_  
*MM/DD/YYYY MM/DD/YYYY*

**How many hours did the applicant work per week?** \_\_\_\_\_

**Number of hours practicing mental health therapy:** \_\_\_\_\_

**Total number of hours practiced as an CSW:** \_\_\_\_\_

**Describe the applicant's duties:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Was the applicant a W-2 employee or contracted labor?** \_\_\_\_\_

**Is the applicant still employed?**  Yes  No

**If no, is the applicant re-hirable?**  Yes  No: **Please explain:** \_\_\_\_\_  
\_\_\_\_\_

I do hereby certify that the applicant for licensure as a certified social worker was actively engaged in the lawful practice as a CSW at the above named establishment for the number listed.

I further certify that the applicant is qualified and competent to practice as a licensed certified social worker.

**Signature of Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Applicant:** \_\_\_\_\_

# Verification of Supervision for Post-Graduate Mental Health Practice Hours

## SUPERVISEE INFORMATION

To be completed by the supervisee.

**Full Legal Name:** \_\_\_\_\_  
*First Middle Last*

**Mailing Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

**License Number:** \_\_\_\_\_ **License Type:** \_\_\_\_\_

## SUPERVISOR INFORMATION

To be completed by the supervisor.

**Full Legal Name:** \_\_\_\_\_  
*First Middle Last*

**Mailing Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

**License Number:** \_\_\_\_\_ **License Type:** \_\_\_\_\_ **Issue Date\*** \_\_\_\_\_

*\*Proposed supervisors must have been actively engaged in licensed practice for at least 2 years before supervising post-graduate hours.*

For Supervisors of AMFT's: Please indicate which of the following you have completed in accordance with Utah Admin Code R156-60b-302d(3).

- Currently approved by AAMFT as an MFT supervisor.
- Successfully completed a supervision course in a COAMFTE accredited MFT program at an accredited university.
- Successfully completed 20 clock hours of instruction sponsored by AAMFT or the Utah Association for Marriage and Family Therapy.

For all license types:

Yes  No Is the supervisee a W-2 employee?

Yes  No Are the supervisor and supervisee working in the same place of employment?

If no, please provide a detailed explanation of how supervision is being conducted:

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

Date supervision contract was signed: \_\_\_\_\_

**I certify I have read Utah Admin. Code R156-60-302. Supervised Training Requirements-Supervision Contract-Duties and Responsibilities of Supervisor and Supervisee. I understand that hours must be documented using the Division provided Post-Graduate Mental Health Supervised Hours form.**

**Signature of Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Supervisee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Supervision for Post-Graduate Mental Health Practice Hours

Use this form to track your supervision as an CSW. Total of all hours must be at least 4,000.  
 Do not turn this form in with your CSW application. It should be turned in with your LCSW application.

## SUPERVISEE INFORMATION

Full Legal Name: \_\_\_\_\_ License Number: \_\_\_\_\_ Email: \_\_\_\_\_  
First      Middle      Last

## SUPERVISED HOURS

Supervised Hours. Use additional sheets as needed.

Supervisor	Dates Supervised <small>(MM/DD/YYYY to MM/DD/YYYY)</small>	Total Hours	Hours of Mental Health Therapy Training	Hours of Direct Supervision	Supervisor's Signature
	<i>to</i>				
	<i>to</i>				
	<i>to</i>				
<b>Total from all supervisors:</b>					

Please list each supervisory meeting. Use additional sheets as needed.

Date	Location	Format <small>(Individual, small group, etc.)</small>	Supervisor	Supervisor Evaluation (use additional sheets if needed)

Signature of Supervisee: \_\_\_\_\_ Date: \_\_\_\_\_

## APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.

**NOTE:** Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

The following items are required to complete your application:

- \$120.00 non-refundable application-processing fee, made payable to DOPL.
- Supporting documentation for any “yes” answers provided on either of the qualifying questionnaires.
- “Verification of Supervision for Post-Graduate Mental Health Practice Hours”, found in this application.  
**Note:** This form is not required to obtain a license, but you cannot begin your post-graduate hours until it is on file and approved by the Division.

### LICENSURE BY APPLICATION

If applying for your initial application or do not qualify for licensure by endorsement, *in addition* to the items required for all applicants, you must submit:

- Official transcripts** documenting completion of a master’s degree. If you submitted transcripts with your request for authorization to test, you do not need to submit them a second time. However, if you applied for exam approval from ASWB in your last semester and provided a letter from your school in lieu of transcripts showing your degree, you must submit official transcripts. **Note:** Transcripts are considered “official” when they are sent directly from the school to DOPL or sealed in an envelope bearing the school’s stamp/seal on the envelope flap.

### LICENSURE BY ENDORSEMENT

If applying **licensure by endorsement**, there are two options. *In addition* to the items required for all applicants, you must submit the following:

- Documentation of at least 3 hours of continuing education in the area of professional ethics and responsibilities and 2 hours in suicide prevention. Hours must have been obtained in the last three years.
- One of the following options:

**Option 1: One Year of Active Licensure from a Jurisdiction Deemed Equivalent.**

- Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah.
- If required, official transcripts and/or exam scores to demonstrate equivalency.

Please see our website for additional information regarding approved jurisdictions, and any additional documentation that may be necessary.

OR

**Option 2: 4000 Hours of Active Licensure from any U.S. Jurisdiction**

- Official verification of license from one or more states in which you are currently licensed. Verifications must cover the time period used to qualify for endorsement.
- “Verification of Active Practice as a CSW” form found in this application. **NOTE:** *You must have each employer complete a separate form, and the hours from all forms must total 4,000.*

Submit the above items with your completed application to:

**In person or via express delivery:**

Division of Occupational and Professional Licensing  
Heber M Wells Building, 1<sup>st</sup> Floor Lobby  
160 E 300 S  
Salt Lake City, UT 84111

**US Postal Service:**

Division of Occupational and Professional Licensing  
PO BOX 146741  
Salt Lake City, UT 84114-6741

If you have questions, please contact the Division via our direct email address: [b3@utah.gov](mailto:b3@utah.gov), or via the phone or fax number listed below. Do not send applications or payments to this email.