UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Clear Form

Licensed Clinical 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:** _____
Note: All Division notices and communication will be sent to this 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
- police report(s)
- court record(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 licensed clinical 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 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 LCSW in Another State

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, a Professional Colleague, 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 LCSW: _____

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 licensed clinical social worker was actively engaged in the lawful practice as a LCSW at the above named establishment for the number listed.

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

Signature of certifying individual: _____

Relationship to Applicant: _____ Date: _____

License Number *(if applicable)*: _____ State of Licensure: _____

SUPERVISION RECORD OF POST-GRADUATE MENTAL HEALTH PRACTICE HOURS

Use this form to report your supervision after obtaining licensure as a Clinical Social Worker. Each Supervisor must complete a separate form. The hours from all forms must total 3,000.

APPLICANT INFORMATION

To be completed by the supervisee.

Full Legal Name: _____
First *Middle* *Last*

License Number: _____ **License Type:** _____

SUPERVISION INFORMATION

To be completed by the Supervisor.

Name of Establishment: _____

Name of Supervisor: _____
First *Middle* *Last*

Email Address: _____
*Note: **REQUIRED** All Division notices and communication regarding supervision will be sent to this email.*

License Number: _____ **License Type:** _____

Dates of Supervision as a W-2 Employee: _____ **to** _____
Note: Intern / Practicum hours can not be counted *MM/DD/YYYY* *MM/DD/YYYY*

☐ **Documented hours of supervised mental health therapy with clients**
As defined in Utah Code 58-60-102(7) and 58-60-205(1)(d)

☐ **Documented hours of mental health training gathered under Direct Supervision**
As defined in Utah Code 58-60-205(1)(e), 58-60-305(1)(e), 58-60-405(1)(e), and 58-60-502(3)

☐ **Documented hours of mental health therapy training**

0 **TOTAL HOURS of documented training under this supervisor**
As defined in Utah Code 58-60-205(1)(d)

☐ **Yes** ☐ **No** **Did the supervisee meet the expectations of supervision outlined in the written plan, with regards to the quality of work performed? If no, submit a written statement regarding the performance to the Division at B8@utah.gov**

☐ **Yes** ☐ **No** **Did the supervisor and supervisee work at the same place of employment? If no, describe how you were able to perform supervision:** _____

_____

I certify that the applicant for licensure as a clinical social worker has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed above and that the experience meets the requirements outlined in Utah Admin. Code R156-60a-302c, and Utah Admin. Code R156-60-302. I further certify that the applicant is qualified and competent to practice as a clinical social worker.

Signature of Supervisor: _____ **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.

ALL APPLICANTS

All applicants are required to submit the following items to complete the 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.

INITIAL LICENSURE

If applying for **Initial Licensure**, *in addition* to the items required for all applicants, you must submit:

- ☐ "Supervision Record of Post-Graduate Mental Health Practice Hours" form found in this application. ***NOTE:*** *Each supervisor must complete the form for the hours they supervised and the hours from all supervisors must total* 3,000
- ☐ Documentation of a two-hour suicide prevention training course.

If applying for Initial Licensure and you did not take the ASWB CLINICAL EXAM to qualify for your CSW license, *you must* pass the ASWB Clinical Exam PRIOR to submitting this application. Please contact ASWB if you have questions on how to register for the exam.

LICENSURE BY ENDORSEMENT

If applying for **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 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: 3,000 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 an LCSW in another state" form found in this application. ***NOTE:*** *You must have each employer complete a separate form, and the hours from all forms must total 3*,000.

If you do not qualify for endorsement and do not hold a Utah CSW license, please contact the board to determine the items needed to complete your application.

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, 1st 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, B8@utah.gov, or via the phone or fax number listed below.