

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

FAX #: (608) 261-7083  
Phone #: (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
E-Mail: web@drl.state.wi.us  
Website: http://drl.wi.gov

## MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

### DOCUMENTATION OF POST-GRADUATE CLINICAL EXPERIENCE – SUPERVISOR’S AFFIDAVIT FOR SOCIAL WORK LICENSE

(Copy this form for completion by each supervisor and/or facility.)

MPSW 3.09(3) of the Wisconsin Administrative Code requires an affidavit that the applicant, after receiving a master’s or doctoral degree, has completed at least 3,000 hours of clinical social work practice in no less than 2 years, including at least 1,000 hours of face-to-face client contact and including DSM diagnosis and treatment of individuals, under the supervision of a supervisor approved by the social work section after receiving a master’s or doctoral degree. Supervised practice shall meet the criteria under s. MPSW 4.01, Wis. Admin. Code.

**Please Type or Print In Ink**

Applicant’s name: \_\_\_\_\_

Name and location of post-graduate clinical experience facility: \_\_\_\_\_

Supervisor’s name: \_\_\_\_\_

Type of credential supervisor holds: \_\_\_\_\_

Supervisor’s credential number: \_\_\_\_\_

Dates the applicant was under your supervision: From (mm/yy) \_\_\_\_\_ To (mm/yy) \_\_\_\_\_

Number of hours of face-to-face client contact: \_\_\_\_\_

Number of hours of face-to-face individual or group supervision: \_\_\_\_\_

Total number of hours of clinical social work practice: \_\_\_\_\_

Briefly describe your facility’s mission \_\_\_\_\_

Briefly describe the clients served at your facility \_\_\_\_\_

Please describe, in detail, the applicant’s experience as follows (attach additional sheets if necessary):

(1) What experience does this applicant have providing therapy, including the type of client and treatment modality.

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

(2) Was the applicant the primary provider of psychotherapy services for his or her clients? If not, please explain.

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

(3) How has this applicant been involved in doing and/or consulting in DSM diagnosis of clients?

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

(4) Does the applicant have the ability to change or recommend changing a client’s DSM-IV diagnosis?

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

*(Please also attach a formal position description.)*

