

VERIFICATION OF FACE TO FACE CLIENT CONTACT

Notice to Applicant: Please complete the first section of this form and send a copy to the director or supervisor of each practice site or agency in which you practiced social work following the receipt of the master's or doctoral degree in social work. You need documentation of at least a minimum of one-thousand (1000) hours of face to face client contact.

I. TO BE COMPLETED BY THE APPLICANT

Applicant's Name _____ SS# _____ - _____ - _____

Address _____
Street City State Zip Phone

Practice Site or Agency _____

Address _____
Street City State Zip Phone

Position/Title _____

Description of Responsibilities _____

Dates of Practice: From _____ To _____
Month/Year Month/Year

Total weeks of practice at this site: _____ Average clinical hours/week _____

Total client contact hours at this site: Individual _____ Groups _____ Total hour _____

Oath and Authorization to Release

I attest that the above information is a true and accurate representation of my experience in the clinical practice of social work at the above site. Further, I authorize the above agency, director or supervisor to release the requested information.

Signature of Applicant

Printed Name

Date

Continued on reverse side

II. TO BE COMPLETED BY PRACTICE SITE DIRECTOR OR SUPERVISOR

Please review the applicant's description of his/her clinical practice of social work at your site/agency. If you have any additional information which would assist the Board in making a decision on licensure for this applicant, please provide that information below:

I attest that I served as (please indicate) director or supervisor for the applicant during the clinical experience described above and that this description is a true and accurate representation of the applicant's clinical experience in social work at this site.

Director or Supervisor's Signature	Printed Name	Date	
Name of Site _____	Phone _____		
Address	City	State	Zip

(If the director or supervisor who worked with the applicant cannot be located, the current director or supervisor may verify the applicant's experience based on a review of the available records.

After a diligent and thorough search of available records, I attest that this description is a true and accurate record of this applicant's clinical experience in social work at this site.

Director or Supervisor's Signature	Printed Name	Date	
Name of Site _____	Phone _____		
Address	City	State	Zip

Please return this completed form directly to the following Board address:

**Mississippi Board of Examiners for
Social Workers & Marriage and Family Therapists
P.O. Box 4508 • Jackson, MS 39296-4508**