

Mississippi

Board of Examiners for Social Workers and Marriage & Family Therapists Post Office Box 4508 * Jackson, MS 39296-4508 601-987-6806 * Fax: 601-987-6808 *

www.swmft.ms.gov * info@swmft.ms.gov

Out-of-State Verification of Licensure

PART I – To be Completed by Applicant

Applicant should complete Part I of this form and send to all licensing boards of the state or jurisdiction in which you have held a social work license. Once they complete Part II, this form should be forwarded to the address at the top of this form. I am applying for a license as a social worker in the State of Mississippi and hereby consent to the release of any information, favorable or otherwise, which you may have concerning my license or my practice.

Applicant's Signature:	Print Full Name:		Last four of SS No:
State verification is requested:	Mississippi License Applied for (select one): LSV		□ LMSW □ LCSW
Part II - To be Completed by Licensure/ Registration Authority ples	0		on of this form by the
Name of Licensee:	Level of Licensure: License No:		
Date of Issue:Is Licen	se Current?]	Expiration Date:	
Licensed by: () ASWB Examination	() Grandfathering	() Reciprocity/Endorsement	() Other
Level of ASWB Exam:	Pass or Fail If grand	dfathered in, did licensee ever tak	te the exam?
If other, please list name of exam?		Level:	Score:
If licensed at the LCSW level, was 2 year	rs of clinical supervision	n completed?	
If yes, please list the dates? From:	to	How many hours were co	ompleted?
Supervisor's Name:		License Number &Leve	l:
Is License in Good Standing? If	no, please explain:		
Any derogatory information?	If yes, please explain: _		
Has License ever been suspended, revok	ed or restricted?	If yes, please attach copies	of any actions.
	/Printed Name	/	
Doord Cool	Title of Board	F	hone Number
Board Seal			

Verification of Education for Licensure in Social Work

Instructions to Applicant:

Name (Last, First, Middle Initial)

Upon completion of the demographic information and waiver below, this form should be signed, notarized, and forwarded to the college of university where you obtained your <u>degree in social work</u> OR you may submit an official transcript sent directly from your institution. The transcript may be emailed to <u>info@swmft.ms.gov</u> directly from the institution. If mailed, it must be in a sealed envelope from the institution.

Maiden Name or Given Surname

Address (Street, City, State, and Zip Code)		Home Phone (Work)		
		()		
Last 4 of Social Security Number Student Identification Number		Date of Graduation		
License Applying For (Check One):				
☐ Social Worker ☐ Master Social Wo	orker Certif	fied Social Worker		
Vaiver For The Release of Information:		Subscribed and sworn before me this day of20_		
I am applying for licensure as a social worker in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi Board of Examiners for Social Workers and Marriage and Family Therapists, should this information be requested at any time.		My commission expires		
		Notary Public		
Date Applicant's Signatu	ure	Seal		
Instructions to Education Institu				
Upon completion of this form please send to:	MS BOARD OF E P.O. Box 4508 Jackson, MS 39290			
Name of Institution		Location of Institution (City & State)		
Date of Attendance (Month/Year)		Total Number of Academic Years		
From: To:				
Date Degree Conferred		Degree Conferred/Awarded		
Program Name & Curriculum Description		Date of Practicum/Internship: From: Month Day Year To: Month Day Year Total Hours:		
		<u>'</u>		
Social Work Program Accredi : (On date degree conferred)	ation Undergradua Graduate:			
		Registrar's Name (print or type)		
Seal of the College or U	^I niversity	Registrar's Signature		
		Telephone Number Date		