



Social Worker License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Social Worker Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. The cost of the background check is at the applicant's expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees. This fee may be paid by a personal check or money order, payable to the Department of Health.

Select if the following applies:
Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information:
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority

3. Other License, Certification, or Registration:

List in date order **all** states, including Washington State, where credentials are or were held. An [Out-of-State Credential Verification form](#) is enclosed and must be sent to each state listed above. Also contact each state board listed for any fees they might charge you for processing the verification form.

4. Education:

List in date order your educational preparation and post-graduate training. Attach additional pages if you need more space.

5. Experience:

Beginning with current employment, list all activities and account for all periods of time from graduation to the present. A resume will **not** substitute for completion of the application. Please use the initials **N/A** (not applicable) if you have not had professional training and experience.

6. Examination Data:

If you have taken the American Association of State Social Work Board’s (ASWB) examination, you are considered to have met the examination requirement. You must get written verification from ASWB, sent directly to the department.

ASWB’s advanced or clinical is acceptable for a license in Washington State. Applicants applying for Licensed Advanced Social Work will be required to pass the advanced exam. Applicants applying for Licensed Independent Clinical Social Work will be required to pass the clinical exam. The state you took either the advanced or clinical exam must verify your score or provide written verification.

7. AIDS Education and Training Attestation:

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in [WAC 246-12-270](#). If AIDS education was included in your professional education or training, an additional course is not required.

8. Continuing Education Attestation:

Complete 36 hours of continuing education, with six in professional ethics. See [RCW 18.225.090](#).

9. Applicant’s Attestation:

You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Experience Requirements:

Licensed Advanced Social Worker

A minimum of 3,200 hours of supervision by an approved supervisor as described in [WAC 246-809-334](#).

Of those minimum 3,200 hours of postgraduate experience:

- 800 hours must be in direct client contact
- 90 hours must be in direct supervision, as follows:
 - 50 hours must be direct supervision with a Licensed Social Worker (LASW or LICSW). These hours may be gained in one-to-one supervision or group supervision.
 - 40 hours may be supervised by an equally qualified Licensed Mental Health Practitioner as defined in [WAC 246-809-310\(3\)](#). These hours must be in one-to-one supervision.

Distance Supervision is limited to 40 hours of supervision.

Licensed Independent Clinical Social Worker

A minimum of 4,000 hours of supervision over a minimum period of three years by an approved supervisor as described in [WAC 246-809-334](#).

Of those minimum 4,000 hours of postgraduate experience:

- 1,000 hours must be in direct client contact supervised by a LICSW.
- 130 hours must be in direct supervision, as follows:
 - 70 hours must be supervised by a LICSW. These hours may be gained in one-to-one supervision or group supervision.
 - 60 hours may be with a LICSW or an equally qualified Licensed Mental Health Practitioner as defined in [WAC 246-809-310\(3\)](#). These hours must be in one-to-one supervision.

Distance Supervision is limited to 60 hours of supervision.

In order for supervision to count towards licensure, all supervision must be gained by an approved supervisor that meets the supervisory requirements.

Examination Information

Once you have been approved to take the examination, you will be sent an approval letter. This letter gives you information on how to register for the examination. You will be taking the examination directly from the American Association of Social Work Board (ASWB). The department receives score reports within six weeks of administration from the testing company.

National Certification

In accordance with [WAC 246-809-321](#), persons who have obtained the Board Certified Diplomate in Clinical Social Work from the American Board of Examiners in Clinical Social Work (ABECSW), Diplomate in Clinical Social Work (DCSW), or Qualified Clinical Social Work (QCSW), from the National Association of Social Workers (NASW) shall be considered to have met the education and postgraduate experience requirements to be eligible for Washington State license examination.

Documentation must be sent directly from the NASW to the Department of Health.

Date
Stamp
Here

Revenue: 0207040000

Social Worker License Application

Check only one: Advanced Independent Clinical

Select if the following applies: Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address (if different from above address of record)

City	State	Zip Code	County
------	-------	----------	--------

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? Yes No
 If yes, list name(s):

Will documents be received in another name? Yes No
 If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ..

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
 - b. Diverted controlled substances or legend drugs?.....
 - c. Violated any drug law?
 - d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Other License, Certification, or Registration

List all states, including Washington State, where credentials are or were held.

State	License/Certification/Registration Type	License/Certification/Registration			Method Licensed	
		Year Issued	Number	Exam	Endorse	Grand Fathered

An Out-of-State Credential Verification form is enclosed and must be sent to each state listed above. Enter your full name and birth date at the top of the form so the state may identify you. Contact each state board listed for any fees they might charge for processing the verification form.

4. Education

Provide a date order listing of graduate school(s) attended, major, month, and year the degree was granted. Request your transcripts from the graduate school(s) you attended, and have the graduate school send **directly** to the Department of Health.

Graduate School	Degree Granted		Degree and Major
	Month	Year	

5. Experience

List all experience in date order, most recent to later. Attach additional pages if you need more space.

Indicate Type of Experience or Practice and Location	Inclusive Dates of Experience	
	Entrance Date (mm/yyyy)	Leaving Date (mm/yyyy)

6. Examination Data

Have you taken and passed the Association of Social Work Board (ASWB) advanced or clinical level examination?

Yes No

Advanced Level Clinical Level Date _____

7. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that if I provide any false information, my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicants Initials	Today's Date

8. Continuing Education Attestation

I, _____, declare I completed 36 hours of continuing
(Print applicant name clearly)
education, with six hours in professional ethics.

Applicants Initials	Date

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)

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Washington State Department of
Health

Social Worker Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been credentialed. Instruct them to return the form directly to the address listed above. Make a copy of this form if you are or have been credentialed in more than one state and/or jurisdiction. Credentialing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process.

Name:	Last	First	Middle
Mailing Address			
City	State	Zip Code	
Any other names used:			
Credential Number		Date Issued	

Have the licensing agency return this completed form to the above address.

Please call 360-236-4700 if you have questions regarding this form.

Out-of-State Credential Verification Cont.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of credential holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by:		
<input type="checkbox"/> Written Examination	Date:	Score:
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "no", please attach explanation.		
Has this credential ever been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No Suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No Revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Surrendered? <input type="checkbox"/> Yes <input type="checkbox"/> No Reinstated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "yes", please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		



Signature:

Title:

Date:

Verification of Social Worker Supervised Postgraduate Experience

Licensed Advanced Social Work (LASW) means the use of social work theory and methods including emotional and biopsychosocial assessment, psychotherapy under the supervision of a licensed independent clinical social worker, psychiatrist, psychiatric advanced registered nurse practitioner or psychiatric nurse.

LASW will only allow you to practice under supervision and is designed for people working in agencies, hospitals, schools, or other institutions. If you choose to become LASW, you will have to reapply to become a Licensed Independent Clinical Social Work (LICSW) if you practice under the definition of an LICSW in the future.

Licensed Independent Clinical Social Work (LICSW) means the diagnosis and treatment of emotional and mental disorders based on knowledge of human development, the causation and treatment of psychopathology, psychotherapeutic treatment practices, and social work practice as defined in advanced social work. Treatment methods include but are not limited to diagnosis and treatment of individuals, couples, families, groups, or organizations.

LICSW will allow you to practice independently or in an agency setting.

The information listed below must reflect only supervision completed post-graduate. Experience gained through inappropriate supervision will **not** count toward the supervised post-graduate experience.

Applicant:

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill in section 1 and forward the verification form to the supervisor for completion

Print Clearly:

Name	Last	First	Middle	Birth date (mm/dd/yyyy)
Address				
City		State		Zip Code

Postgraduate Supervised Experience for Advanced Social Worker:

Minimum of 3,200 hours of supervision by an approved supervisor as described in

[WAC 246-809-334](#).

Of those minimum 3,200 hours of postgraduate experience:

- 800 hours must be in direct client contact
- 90 hours must be in direct supervision, as follows:
 - 50 hours must be direct supervision with a Licensed Social Worker (LASW or LICSW). These hours may be gained in one-to-one supervision or group supervision.
 - 40 hours may be supervised by an equally qualified Licensed Mental Health Practitioner as defined in [WAC 246-809-310\(3\)](#). These hours must be in one-to-one supervision.

Distance Supervision is limited to 40 hours of supervision.

Months of supervision: From _____ To _____
(mm/dd/yyyy) (mm/dd/yyyy)

Indicate number of hours of direct client contact—800 hours required	
Indicate number of hours of one-on-one supervision	
Indicate number of hours of group supervision	
Total number of hours—3,200 hours required	

Postgraduate Supervised Experience for Independent Clinical Social Worker:

A minimum of 4,000 hours of supervision over a minimum period of three years by an approved supervisor as described in [WAC 246-809-334](#).

Of those minimum 4,000 hours of postgraduate experience:

- 1,000 hours must be in direct client contact supervised by a LICSW.
- 130 hours must be in direct supervision, as follows:
 - 70 hours must be supervised by an LICSW. These hours may be gained in one-to-one supervision or group supervision.
 - 60 hours may be with an LICSW or an equally qualified Licensed Mental Health Practitioner as defined in [WAC 246-809-310\(3\)](#). These hours must be in one-to-one supervision.

Distance Supervision is limited to 60 hours of supervision.

In order for supervision to count towards licensure, all supervision must be gained by an approved supervisor that meets the supervisory requirements.

Months of supervision: From _____ To _____
(mm/dd/yyyy) (mm/dd/yyyy)

Indicate number of hours of direct client contact—1,000 hours required	
Indicate number of hours of one-on-one supervision	
Indicate number of hours of group supervision	
Total number of hours—4,000 hours required	

Supervisor:

The above individual seeks license as an Advanced Social Worker or Independent Clinical Social Worker in Washington and requires verification of postgraduate supervision and postgraduate professional experience. Please complete the following:

Supervisor Name		Current Phone (enter 10 digit #)
Current Address		
City	State	Zip Code
License Number		Date (mm/dd/yyyy)

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature _____ Date _____

Return this form directly to the address listed on page one.

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Washington State Department of

Health

Social Worker Credentialing

P.O. Box 47877

Olympia, WA 98504-7877

360-236-4700

Approved Supervisor Licensed Social Worker

To the Supervisor:

In accordance with [RCW 18.225.090](#), to provide supervision to a Licensed Advanced Social Worker (LASW) or Licensed Independent Clinical Social Worker (LICSW) one must be licensed or certified for at least two years and have two years of clinical experience post licensure.

Please review [WAC 246-809-334](#). To supervise a license candidate, you must hold a license without restrictions that has been in good standing for at least two years.

You shall not be a blood or legal relative or cohabitant of the license candidate, license candidate's peer or someone who has acted as the license candidate's therapist within the last two years.

Prior to the commencement of any supervision you must provide the license candidate with this declaration, stating you have met the requirements of [WAC 246-809-334](#) and you qualify as an approved supervisor.

As an approved supervisor, I attest I have completed the following:

- A minimum of fifteen clock hours of training in clinical supervision obtained through:
 - A supervision course.
 - Continuing education credits on supervision.
 - Supervision of supervision.
- And twenty-five hours of experience in supervision of clinical practice
- And has two years of clinical experience post license.

I attest I will gain thorough knowledge of the supervisee's practice activities including:

- Practice setting.
- Recordkeeping.
- Financial management.
- Ethics of clinical practice.
- A backup plan for coverage.

Declaration of Supervision – must be completed by Supervisor and provided to license candidate prior to the commencement of supervision in accordance with [WAC 246-809-334](#).

I, _____ am licensed as a _____
(Name of Supervisor)

in the State of _____ with license number _____

I attest to _____ that I have read and met all the requirements in connection
(Name of Candidate)

with [WAC 246-809-334](#).

Signature of Supervisor

Date

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RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act RCW, 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Licensed Social Worker Laws, RCW 18.225](#)

[Licensed Social Worker Rules, WAC 246-809](#)

[Standards of Professional Conduct, WAC 246-16](#)

On-Line

[AIDS Training Resources Reference Page](#)

[Social Worker Program, Web Page](#)