



Arkansas Department of Health

Social Work Licensing Board

5800 West 10th, Suite 100, Little Rock, AR 72204 * (501) 372-5071 * Fax (501) 372-6301
 Mailing Address: P. O. Box 251965, Little Rock, AR 72225
swlb@arkansas.gov * <http://www.arkansas.gov/swlb/>

Governor Asa Hutchison
 José Romero, MD, Secretary of Health
 Ruthie Bain, Director

LCSW Supervision Evaluation

Supervisee: _____ License #: _____

Supervisor: _____ License #: _____

Dates of Supervision: From: _____ To _____ # of Months: _____
Month/Day/Year (same as on your Plan) Month/Day/Year

Average hours spent in weekly supervision: Individual _____ Group _____

Total Individual Hours: _____ Total Group Hours: _____ Overall Direct Supervision Hours: _____

Total number of hours worked in a social work position during this time period: _____

| Evaluate the applicant/supervisee on the following: | Unable to Evaluate | Poor | Average | Above Average | Superior |
|---|--------------------|------|---------|---------------|----------|
| Practice Skills | | | | | |
| 1. Ability to assess/understand/access systems | | | | | |
| 2. Individual/Family/Group Therapy | | | | | |
| 3. Ability to identify and apply most applicable clinical model(s) | | | | | |
| 4. Appropriate referral making skills | | | | | |
| 5. Ability and willingness to self-assess | | | | | |
| 6. Understand system development and policy implications | | | | | |
| 7. Planned action implementation | | | | | |
| Skills Required for Continuing Competence | | | | | |
| 1. Recognition of own limitations | | | | | |
| 2. Understanding of intra/inter dependence of systems of care | | | | | |
| 3. Capacity for professional and personal growth and development | | | | | |
| Development of Professional Identity | | | | | |
| 1. Colleagues/peers perception of clinician's skills | | | | | |
| 2. Ability to establish and maintain good professional relations | | | | | |
| 3. Ability to identify, organize and manage agency goals and objectives | | | | | |
| Ethical Practice | | | | | |
| 1. Understanding of & adherence to approved standards of professional/ethical conduct | | | | | |
| 2. Personal Character: honesty, integrity, respect, service, general conduct, etc | | | | | |
| 3. Sense of responsibility to client, community, agency and profession | | | | | |

Please provide any additional information regarding the evaluation above that you may consider relevant.

I certify that the information above is true and correct to the best of my knowledge. I fully understand that all statements made on this form are subject to verification and that any false and misleading answer may be grounds for refusal or subsequent revocation or suspension of my license.

Signature of Supervisor: _____ Date: _____

This evaluation has been discussed with me, and I have received a copy of it.

Signature of Supervisee: _____ Date: _____

The supervisee must email, mail or fax this form to the Social Work Licensing Board **within 60 days from the last date of supervision**. This is the LMSW's responsibility.