

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 * www.arkansas.gov/swlb

Governor Sarah Huckabee Sanders Renee Mallory, RN, BSN, Interim Secretary of Health Ruthie Bain, Director

VERIFICATION OF LICENSURE IN OTHER STATE

<u>Direction to Applicant:</u> Complete Part I and forward this form to the state(s) where you currently hold or have held a license, registration, or certification to practice social work. Note: Some Board charge fees to verify or endorse your license. Please check with the appropriate board and remit any necessary fees with this form.

PART I – To be completed by the applicant:		
Name of Applicant	State from which verification Requested	License No.
I was granted a license as described above ar Licensing Board. Verification may be sent to t	nd request that verification of that license be submitte the mailing address above.	d to the Arkansas Social Work
You are herby authorized to release any infor	rmation in your files, favorable or otherwise, directly t	o the Arkansas Board.
	Signature	 Date
PART II – To be completed by the State Board Please complete this form and return the ma	d Verifying Licensure: iling address above. A computer-generated form is als	o acceptable.
Name of Licensee	License Level Number	Issue Date
Please verify requirement met in your State:		
BSW from CSWE Accredited School	MSW from CSWE Accredited School Other	r(Specify)
	r of supervision hour required Number of n at the time of issuance? Yes No Please a	
Exam Taken:ASWB BachelorsASN Other, please specify	WB MastersASWB Clinical Date Passed	
If no exam was taken, how was license obtain	ned? Grandfathered Endorsement What	State?
License Current? Yes No Expirati	on Date:	
Complaints and/or Disciplinary Action? Yes_	No If yes, please attach explanation	n or copy.
	Signature	Date
BOARD SEAL		
	Printed Name	Title