

Licensed Clinical Social Worker

Initial Licensure Application Endorsement Application

APPLICANT INFORMATION

Full Legal Name: _____
First Middle Last

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN:* _____ Date of Birth: _____ Gender: Male Female
* If you don't have a social security number, please follow the instructions on the last page.

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____
Note: All Division notices and communication will be sent to this email.

Please select one:

- I am a United States citizen or a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: _____

Driver License or State ID Card: _____
State of Issue License Number Expiration Date

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of Applicant: _____ Date: _____

PRIVACY NOTICE

The information you provide on this form will be used to determine your eligibility for a license, registration, or certification in Utah. Failure to provide complete information as requested will result in the denial of your request as incomplete.

Information provided in this form is retained in accordance with state record retention laws. For specific information about the records retention for this form, please visit <https://dopl.utah.gov/records>.

To comply with legal and regulatory requirements, we may share limited information about your license, registration, or certification with authorized parties. This may include government agencies, national databases, and contracted vendors. Shared information may include issue date, status, expiration date, disciplinary actions, and your name or other direct identifiers.

We may also share aggregated and de-identified data (e.g., education levels, exam pass rates, length of licensure, etc.) with relevant stakeholders for data analysis and reporting purposes.

ACKNOWLEDGEMENT:

Your signature acknowledges receipt of this information.

Authorized Signature: _____ Date: _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

-
1. Yes No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?
-
2. Yes No Do you CURRENTLY have **any criminal action active or pending**?
-
3. Yes No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **misdemeanor** in any jurisdiction?
-
4. Yes No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a felony in any jurisdiction?
-

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- court record(s)
- police report(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's [criminal history FAQs](#).

PROFESSIONAL LICENSES

List all other licenses, registrations or certifications issued by any state in which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

If you identified a Clinical Social Worker license above, please answer the following:

- Yes No After obtaining the license(s) above, have you engaged in at least one year of experience in the jurisdiction where the license was issued?

NOTE: If you answer yes to the question above, please see the checklist at the end of this application or [our website](#) for instructions on applying by endorsement.

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:
 - Yes No a hospital or health care facility
 - Yes No Medicaid, Medicare or any other state or federal health care payment reimbursement program
 - Yes No the Federal Drug Enforcement Administration or any state drug enforcement agency
 - Yes No malpractice insurance coverage
 - Yes No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:
 - Yes No a hospital or health care facility
 - Yes No Medicaid, Medicare or any other state or federal health care payment reimbursement program
 - Yes No The Federal Drug Enforcement Administration or any state drug enforcement agency
 - Yes No malpractice insurance coverage
 - Yes No other entity: _____

3. Is any action pending against you now by:
 - Yes No a hospital or health care facility
 - Yes No Medicaid, Medicare or any other state or federal health care payment reimbursement program
 - Yes No the Federal Drug Enforcement Administration or any state drug enforcement agency
 - Yes No malpractice insurance coverage
 - Yes No other entity: _____

4. Yes No Have you been named as a defendant in a malpractice suit?

5. Yes No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered "Yes" to question 4, you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: <http://www.npdb.hrsa.gov>.*

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

NATIONAL PROVIDER IDENTIFIER (NPI)

Your NPI: _____

EXAM REQUIREMENTS

Select one:

- I have passed the ASWB Clinical Exam for Utah
- I have passed the ASWB Clinical Exam in another state.

CRIMINAL HISTORY DISCLOSURE STATEMENT

Fingerprints submitted with this application are used to complete a search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Prior to submitting fingerprints, you must read and acknowledge, by signing the affidavit below, the Privacy Act Statement found at: <https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement> . Physical copies of this statement may also be obtained upon request from the Division.

The criminal record information obtained by this search will be used by Division staff to evaluate your ability to obtain licensure in Utah. You may challenge or review your criminal record. For additional information regarding the challenge or review process, please see below.

By signing below, you acknowledge receipt of this information and consent to the background check process described above.

Signature: _____ Date: _____

Printed Name: _____

Please see our website, www.dopl.utah.gov/fingerprints.html, for required information and approved locations to obtain fingerprints. Fingerprint cards may be completed at an approved vendor or you may mail two (2) FD-258 fingerprint cards to our office.

Completed fingerprint cards can be mailed to:
Division of Professional Licensing
P.O. Box 146741
Salt Lake City, UT 84114-6741

REVIEW OF YOUR CRIMINAL RECORD: If you wish to review or challenge the accuracy of the information in your FBI record, you should contact the agency that contributed the information in question. You may also direct the challenge to the FBI. Please see their website at: <https://www.fbi.gov/services/cjis/identity-history-summary-checks>. You may also contact them via mail at: FBI: CJIS Division, Attn. Criminal History Analysis Team 1, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

If you wish to review or challenge the accuracy of the information in your BCI record, you must complete the required "Record Challenge Form", available at: <https://bci.utah.gov/criminal-records/criminal-records-forms/>, and submit it directly to BCI.

Agency review of a licensing decision based on your criminal record may be obtained by filing a written request for agency review with the Executive Director of the Department of Commerce within thirty (30) days after notification of the decision. Any such request must comply with the requirements of [Utah Code § 63G-4-301](#) and [Utah Admin. Code R151-4-902](#).

CSW RECORD of CLINICAL SUPERVISION

Use this form to record your clinical supervision **AFTER** obtaining licensure as an Associate level license holder.
Each Supervisor must be approved by the Division BEFORE you begin accruing hours, NO EXCEPTIONS.
 Clinical Supervision hours may **NOT** be obtained while completing the education requirements for licensure.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____
First Middle Last

Associate License Number: _____ Date Issued: _____

CLINICAL SUPERVISOR INFORMATION (TO BE COMPLETED BY THE SUPERVISOR)

Supervisor Name: _____
First Middle Last

License Type: _____ License Number: _____ State of Issue: _____

NOTE: if the supervisor listed above is licensed outside of the state of Utah an official verification of the supervisor's license, showing it is active and in good standing, must be submitted with this form.

CLINICAL SUPERVISOR INFORMATION (TO BE COMPLETED BY THE SUPERVISOR)

DATES SUPERVISION COMPLETED THROUGH _____ to _____	TOTAL HOURS IN EACH CATEGORY COMPLETED UNDER THIS CLINICAL SUPERVISION
DIRECT CLIENT CARE	
DIRECT CLINICAL SUPERVISION	
DIRECT OBSERVATION	
INDIRECT DUTIES & ACTIVITIES	
CLINICAL SUPERVISION (TOTAL)	

Signature of Supervisor: _____ Date: _____

CLINICAL SUPERVISION DEFINITIONS

Clinical Supervision Hours – 3,000 Hours or Not Less Than Two Years

Clinical Supervision Hours means work experience conducted under the supervision of a clinical supervisor, including: The practice of mental health therapy, direct client care, direct clinical supervision, direct observation, and other duties and activities completed in the course of the day-to-day job functions and work, wherein the supervisor is available for consultation with the supervisee by personal face to face contact, or direct voice contact by telephone, radio, or some other means within a reasonable time consistent with the acts and practices in which the supervisee is engaged, and **MUST** include the Following:

Direct Client Care Hours: MUST INCLUDE the practice of mental health therapy, the utilization of patient-reported progress and outcomes to inform care, and direct observation. Hours in this category, from all supervisors, must total at least 1,200.

Direct Clinical Supervision: MUST INCLUDE the supervisee and their direct clinical supervisor meeting in real time and in accordance with the supervision contract. "Direct clinical supervision" may include group supervision of up to 2 supervisees present. Hours in this category, from all supervisors, must total at least 100.

Direct Observation: MUST INCLUDE observation of a supervisees live or recorded direct client care by the supervisee's clinical supervisor OR a license holder observer who the supervisees direct clinical supervisor approves; and after which, the supervisee and the approved license holder observer meet, in-person or electronically, to discuss the direct client care for the purpose of developing the supervisees clinical knowledge and skill. Hours in this category, from all supervisors, must total at least 25.

Group Supervision with 3 or more supervisees: NO MORE THAN 25 hours, from all supervisors, allowed in this category.

Applicant Full Legal Name: _____
First Middle Last

Clinical Supervisor Name: _____ License Number: _____

CLINICAL SUPERVISION ATTESTATION

(TO BE COMPLETED BY THE SUPERVISION)

I certify that the applicant for licensure has successfully completed the clinical supervision, which includes direct client care, direct clinical supervision, direct observation, and may include group supervision as attested by my signature on the record of Clinical Supervision Hours Form.

I further certify that the clinical supervision provided meets the requirements outlined in [Utah Code 58-60-506](#). During the clinical supervision period for this applicant for licensure, I approved the following license holder(s) to participate in Direct Observation.

Approved Licensed Observers Name: _____
First Middle Last

License Number: _____ License Type: _____

Approved Licensed Observers Name: _____
First Middle Last

License Number: _____ License Type: _____

Approved Licensed Observers Name: _____
First Middle Last

License Number: _____ License Type: _____

Signature of Supervisor: _____ Date: _____

As a supervisor you are required to sign off for clinical supervision hours legally obtained by a supervised individual . However, if the supervised individual did NOT meet the expectations of clinical supervision regarding the quality of work performed, submit a written statement regarding the performance to the Division at B8@utah.gov. All submitted statements will be reviewed by the Behavioral Board.

NOTE: This Supervisor Attestation must be completed by every clinical supervisor who had signed the Record of Clinical Supervision Hours from Verifying hours.

Verification of Active Practice as a LCSW in another State

*For endorsement applicants applying by via **Option 2**. See checklist for additional information*

Applicants using **Option 1** do not need to complete this form.

Each employer must complete a separate form.

APPLICANT INFORMATION

(TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

License Number: _____ State of Issue: _____

EMPLOYMENT INFORMATION:

(TO BE COMPLETED BY THE EMPLOYER, A PROFESSIONAL COLLEAGUE, OR HUMAN RESOURCES.)

Name of Establishment: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____

Dates of Employment: _____ to _____

How many hours did the applicant work per week? _____

Number of hours practicing mental health therapy: _____

Total number of hours practiced as a LCSW: _____

Describe the applicant's duties: *(attach additional form if needed)*

Is the applicant still employed? Yes No

The applicant is/was a W-2 Employee Contracted Labor.

If no, is the applicant re-hirable? Yes No

If Not re-hirable, Please explain:

ATTESTATION:

I do hereby certify that the applicant for licensure as a clinical social worker was actively engaged in the lawful practice at the above-named establishment for the number of hours listed.

I further certify that the applicant is qualified and competent to practice as a licensed clinical social worker.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of certifying individual: _____ Date: _____

Relationship to Applicant: _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.

NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information that is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other laws.

If you do not have a valid Social Security number, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer ([Utah Admin. Code R156-1-301](#)). Submission of the above documents may require additional documents to demonstrate lawful presence ([Utah Code § 63G-12-402 \(3\)\(k\)](#)).

ALL APPLICANTS

The following items are required to complete your application:

- \$152.00 non-refundable application-processing fee, made payable to DOPL.
- Supporting documentation for any “yes” answers provided on either of the qualifying questionnaires.
- Documentation of at least 2 hours in suicide prevention. Hours must have been obtained in the last two years.
- Fingerprints completed at an approved vendor or mailed to the Division. Please see www.dopl.utah.gov/fingerprints.html for required information and approved locations to obtain fingerprints.

LICENSURE BY APPLICATION

If applying for your **Initial Licensure**, or you do not qualify for licensure by endorsement, *in addition* to the items required for all applicants, you must submit:

- “Record of Clinical Supervision”, found in this application. **Note:** *Each supervisor must complete the form for the hours they supervised and the hours from all supervisors must total, at minimum, 3,000.*
- If applying for Initial Licensure, you must pass the ASWB Clinical Exam PRIOR to submitting this application. Please contact [ASWB](#) if you have questions on how to register for the exam.
- Proof of 2 hours of continuing education in suicide prevention.

LICENSURE BY ENDORSEMENT

If applying for **licensure by endorsement**, there are two options. In addition to the items required for all applicants, you must submit the following:

- Option 1:** One Year of Active Licensure from a [jurisdiction deemed equivalent](#).
 - Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah.
 - If required, official transcripts and/or exam scores to demonstrate equivalency.

Please see our website for additional information regarding approved jurisdictions, and any additional documentation that may be necessary.

OR

- Option 2:** 4,000 Hours of Active Licensure from any U.S. Jurisdiction
 - Official verification of license from one or more states in which you are currently licensed. Verifications must cover the time period used to qualify for endorsement.
 - “Verification of Active Practice as a LCSW in another state” form found in this application. **Note:** *You must have each employer complete a separate form, and the hours from all forms must total, at minimum, 4,000.*

Submit completed application to the Division:

By US Postal Service:
Division of Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

By in-person or express delivery:
Division of Professional Licensing
Heber M Wells Building, 1st Floor
160 E 300 S
Salt Lake City, UT 84111