Reset Form

APPLICATION FOR LICENSURE AS A BACHELOR'S DEGREE SOCIAL WORKER (LBSW), A CLINICAL SOCIAL WORKER (LCSW), OR A SOCIAL WORKER (LSW)

State Form 50325 (R13 / 3-25)

Approved by State Board of Accounts, 2017

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
Email: pla8@pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 839 IAC 1-2-5.*
2. *If applying for a temporary permit, please include your fee of $25.00 in accordance with 839 IAC 1-2-5.*
3. *Completed application and fees should be mailed to the address listed in the upper right-hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

FOR OFFICE USE ONLY	
Application Fee	Permit fee
Date fee paid *(month, day, year)*	Date fee paid *(month, day, year)*
Receipt number	Receipt number
License number issued	Permit number issued
License issuance date *(month, day, year)*	Permit issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

License Type (check only one):
☐ Bachelor's Degree Social Worker (ASWB Bachelor Exam)
☐ Social Worker (ASWB Master Exam)
☐ Clinical Social Worker (ASWB Clinical Exam)

Obtained by Method:
☐ Examination ☐ Reciprocity

Do you wish to apply for a temporary permit?*

**One permit allowed per applicant. Temporary permit applicants are required to meet and are subject to the requirements provided under:*
(1) IC 25-23.6-5-11.5, for bachelor's degree social worker (LBSW) and social worker (LSW) license applicants.
(2) IC 25-23.6-5-11 and 839 IAC 1-3-2.5, for clinical social worker (LCSW) license applicants.

☐ Yes ☐No

APPLICANT INFORMATION

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Name of applicant (*last, first, middle*)			Social Security number*
Date of birth (*month, day, year*)	Gender** ☐Male ☐Female	Telephone number (*daytime*) ( )	E-mail address
Address of applicant (*number and street or rural route*)		City, state, and ZIP code	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ I am authorized by the federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐No	Are you an active-duty member of the military? *(Optional)* ☐ Yes ☐No

ORGAN & TISSUE DONOR

In 2022, the Indiana State Legislature passed a law (SEA 260) allowing Indiana residents to sign up as organ donors when seeking or renewing professional licenses via the Indiana Professional Licensing Agency. More than 100,000 people are awaiting a lifesaving transplant, and more than 1,000 of those waiting are Hoosiers, so your decision to say "yes" can truly help save lives.

By selecting "yes", I affirm that I wish to be an organ donor upon my death. I would like to donate all organs for transplant, research, and education. At the time of my death, I understand that my family cannot override my decision. I understand this online sign-up is binding and is a legal document of gift. I do solemnly swear, affirm or certify that I am the applicant described in this application and that the information entered herein is true and correct.

Do you want to sign up to be an organ and tissue donor? ☐ Yes ☐ Not Today

EXAMINATION INFORMATION

ELIGIBILITY FOR EXAMINATION PRIOR TO GRADUATION [SOCIAL WORKER (LSW) APPLICANTS ONLY]

Pursuant to IC 25-23.6-5-4, social worker (LSW) applicants who are:

(1) Enrolled in the last "term" of the last year of their program leading to their degree that meets the requirements of IC 25-23.6-5-1; and
(2) provide a "Letter of Good Standing" from the director of the social work department or the director's designee;

may take the examination provided by the Behavioral Health and Human Services Board (the ASWB Masters Examination) prior to graduation.

The "Letter of Good Standing" provided by the director or the director's design must include the follow information:

(1) The applicant's first and last name.
(2) The type of degree and program in which the applicant is enrolled.
(3) A statement confirming that the applicant is currently in the final term of the program.
(4) The anticipated date of completion of the program.
(5) A statement confirming that the applicant is in good academic standing.

LSW applicants who meet these eligibility requirements and are interested in being approved to register and take the ASWB Masters Examination during their last "term" prior graduation should indicate their interest by "checking" the box below and supply their "Letter of Good Standing" with this application.

☐ I affirm that I meet the eligibility requirements provided above, and I would like to be approved to register and take the Behavioral Health and Human Services Board's examination (the ASWB Masters Examination), towards my LSW license. I affirm that I am including my "Letter of Good Standing" with this application.

If you have already passed an ASWB Examination, please provide the following information

Date *(month, day, year)*:	State:	Level of Examination:

UNDERGRADUATE AND GRADUATE EDUCATION

Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS		
Please list all places of professional employment, including self-employment. You may add an additional sheet listing employment if more space is needed. LBSW applicants are not required to complete this section. All other applicants are required to complete the employment history.		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month, year*)	Average hours per week
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Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		

STATES LICENSED

List all states and territories, ***including Indiana,*** in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly to the board from the state/territory that issued each license. *Licenses issued by the Indiana Professional Licensing Agency will not need verifications.*

Type of License / Certificate / Registration / Permit	State	Number	Date Issued *(month, day, year)*	Status

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied license, certificate, registration or permit to practice any regulated health occupation in any state (*including Indiana*), country or U.S. Territory?	Yes	No
3. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner?	Yes	No
4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*		
(1) have you ever been arrested;	Yes	No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, of felony in any state;	Yes	No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	Yes	No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	Yes	No
(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	Yes	No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline of limitations?	Yes	No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	Yes	No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)

FORM I - VERIFICATION OF SUPERVISION FOR CLINICAL SOCIAL WORKER (LCSW) LICENSURE APPLICANTS

Part of State Form 50325 (R12 / 8-24)

GENERAL INSTRUCTIONS: *All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.*

SECTION A / APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B.*** *You must submit at least twenty-four (24) month of clinical social work supervision after receiving a graduate degree in social work and under the supervision of an Indiana LCSW. The supervision must occur while you are employed for no less than twenty-four (24) months and under an "Active" Indiana LSW license. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name of applicant (*last, first, middle*)	Maiden or given surname	Date of birth (*month, day, year*)
Address (*number and street or rural route, city, state, and ZIP code*)		
Name of supervisor	Name of business / institution	
Supervisor title	Address (*number and street, or rural route, city, state, and ZIP code*)	

I hereby authorize,_____to furnish to the Professional Licensing Agency with the information below.
(*Name of Supervisor*)

Signature of applicant	Date (*month, day, year*)

SECTION B / SUPERVISOR INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: *Complete this section. All supervision may be completed either in person or virtual. However, any completed virtual supervision is required to meet the definition of "virtual supervision" under IC 25-23.6-5-3.5.*

SUPERVISOR INFORMATION

Name of supervisor (*last, first, middle*)	Name of business / institution	
State license / certificate number / type of license / certificate	License / certificate issued by	Business telephone number (*include area code*) ( )
Business address (*number and street or rural route, city, state, and ZIP code*)		
Number of years of experience in Social Work or Clinical Social Work		E-mail address

APPLICANT EMPLOYMENT INFORMATION

Applicant's job title during the time of your supervision	Applicant's employer during the time of your supervision
Date supervision began (*month, day, year*)	Date supervision ended (*month, day, year*)

Number of hours applicant worked per week	Number of hours you supervised applicant per week face-to-face	Number of face-to-face client contact hours per week

Brief description of how supervision was conducted:

I was present at the applicant's place of work. ☐ True ☐ False

The applicant's work requirement was at a different site but:

(1) There was an equivalent supervisor on site. ☐ True ☐ False

(2) The applicant was not engaged in independent private practice. ☐ True ☐ False

I affirm that the supervision is true and correct to the best of my knowledge and belief including that any virtual supervision completed met the definition under IC 25-23.6-5-3.5.

Signature, [please provide your professional credential (i.e., LCSW): _____

Title: _____

Date *(month, day, year)*: _____

(Continued on the reverse side.)

FORM I - VERIFICATION OF SUPERVISION FOR CLINICAL (LCSW) LICENSURE APPLICANTS *(continued)*

Part of State Form 50325 (R12 / 8-24)

SECTION C / AFFIRMATION OF SUPERVISION [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming supervision received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate below the reason the applicant's direct supervisor is no longer able to complete SECTION B.

The applicant's direct supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Supervision was provided by:

(Name of supervisor / last, first, middle, maiden)

Applicant's job title during the time of supervision	Applicant's employer during the time of supervision
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*
Number of hours applicant worked per week	Number of face-to-face supervised hours per week
Brief description of how supervision was conducted:	
I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete and correct.	
Signature of professional colleague	Date *(month, day, year)*

(Continued on reverse side)

FORM II - VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR CLINICAL (LCSW) LICENSURE APPLICANTS

Part of State Form 50325 (R12 / 8-24)

GENERAL INSTRUCTIONS: *All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.*

SECTION A / APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B****. You must submit at least twenty-four (24) months of clinical social work experience after receiving a graduate degree in social work and under the supervision of an Indiana LCSW. This employment must be no less than twenty-four (24) months and while the applicant holds an Indiana Active LSW license. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. This form may be duplicated if your experience was completed at more than one place of employment. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name of applicant (*last, first, middle*)	Maiden or given surname
Address (*number and street or rural route, city, state, and ZIP code*)	Date of birth (*month, day, year*)
Name of business / institution	Address (*number and street, or rural route, city, state, and ZIP code*)
Date you began taking classes to complete your MSW degree: (month, day, year)	Date your MSW degree was granted: (month, day, year)

I hereby authorize,_____ to furnish to the Professional Licensing Agency with the information below.
(*Name of Employer*)

Signature of applicant	Date (*month, day, year*)

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: Complete this section.

EMPLOYER INFORMATION

Name of direct supervisor/employer	
Name of business / institution where employed	E-mail address
Business address (*number and street or rural route, city, state, and ZIP code*)	

Business / Institute telephone number ( )	Date employment began (*month, day, year*)	Date employment ended (*month, day, year*) (*if currently employed, please indicate*)
Position held		Number of hours applicant worked per week

Brief description of the responsibilities that the applicant had while in your employment:

The above indicated supervision was performed by me pursuant to my order, control, and full professional and legal responsibility as a supervisor. **I do hereby declare that the information contained herein is true and correct.**

Signature:_____

Title: _____

Date *(month, day, year)*: _____

(Continued on the reverse side.)

(Continued on reverse side)

FORM II - VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR CLINICAL (LCSW) LICENSURE APPLICANTS *(continued)*

Part of State Form 50325 (R12 / 8-24)

SECTION C / AFFIRMATION OF EXPERIENCE [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming experience received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

The applicant's direct supervisor is unable to complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of employer		
Name of business / institution where employed		E-mail address
Business address *(number and street, city, state, and ZIP code)*		
Telephone number of business / institution	Date employment began *(month, day, year)*	Date employment ended (month, day, year) If currently employed, please indicate
Position held		Number of hours applicant worked per week
Provide a brief description of job duties:		
I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete and correct		
Signature of professional colleague		Date *(month, day, year)*

(Continued on reverse side)

FORM III - VERIFICATION OF GRADUATE COURSEWORK FOR LICENSURE AS A SOCIAL WORK (LSW) AND CLINCAL SOCIAL WORKER (LCSW)

Part of State Form 50325 (R12 / 8-24)

To be completed by all applicants for LCSW licensure who began taking classes to complete a MSW degree after July 1, 1997

Please list the course titles in the areas indicated below, of the graduate courses, exactly as they appear on your transcript, that in your opinion, meet the following requirements. If two or more courses combine meet the criteria, list all courses that may apply. Only graduate level courses are acceptable. The board will not accept coursework counted or credited toward an undergraduate degree.

Psychopathology

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Clinical Practice with Diverse Populations

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Clinical Theory and Practice

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Family Practice

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Group Practice

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Human Behavior in the Social Environment

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Practice Evaluation (Research)

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

I, the undersigned applicant for Clinical Social Worker's licensure, do hereby certify that I have also completed the following:

A supervised field placement that was a part of my advanced concentration in direct practice during which I provided clinical services directly to clients.

Signature of applicant	Date (*month, day, year*)

Printed name of applicant