

STATE OF HAWAII  
SOCIAL WORKER PROGRAM  
Department of Commerce and Consumer Affairs  
PVL Licensing Branch  
335 Merchant Street, Room 301, Honolulu, HI 96813  
P.O. Box 3469  
Honolulu, Hawaii 96801  
Access this form via website at: [hawaii.gov/dcca/pvl](http://hawaii.gov/dcca/pvl)

**VERIFICATION OF SUPERVISED CLINICAL SOCIAL WORK EXPERIENCE**

Instructions to Supervisor:

Please complete the "Verification of Supervised Clinical Social Work Experience" form to verify the number of clinical social work hours that the applicant completed under your supervision. **THE FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.**

\_\_\_\_\_  
(Print Name of Applicant)

This is to certify that, \_\_\_\_\_,  
(Name of Applicant)

has been under **my** supervision from \_\_\_\_\_ through \_\_\_\_\_ and has  
(month and year) (month and year)

successfully completed a total of \_\_\_\_\_ hours of psychotherapy, assessment, and clinical diagnosis; a total of  
(number)

\_\_\_\_\_ hours of client-centered advocacy, consultation, and evaluation; and a total of \_\_\_\_\_ hours of direct  
(number/no more than 900 hrs.) (number)

face-to-face supervision at the agency listed below. I further certify that during the period listed above, I supervised a total of \_\_\_\_\_  
(number)

individuals, and \_\_\_\_\_ individuals in a small group setting.  
(number/up to six supervisees)

Subscribed and sworn to before me this _____ day of _____ A.D. 20 _____. Notary Signature: _____ Notary Public, State of: _____ My commission expires: _____ Print Name: _____
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_____ Signature	_____ Date
_____ Print Name and Title	
_____ Type of License, License Number and State Issued	
_____ Name of Credential and Name of Credentialing Agency	

Doc. Date: _____ No. of Pages: _____ Notary Name: _____ Circuit Court: _____ Doc. Description _____ _____ Notary Signature: _____ Date _____
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_____ Number of Hours of Post-Graduate Clinical Experience in Assessment, Clinical Diagnosis and Psychotherapy that the <b>supervisor</b> completed.		
_____ Name of Agency		
_____ Address		
_____ City	_____ State	_____ Zip Code
_____ Telephone No. (include area code)		

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.