STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Social Worker Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Paul R. LePage
Governor

Anne L. Head
Commissioner

VERIFICATION OF CONSULTATION FORM

Use a separate form for each person verifying experience and for each employment setting. If more space is needed, attach an additional sheet. Please print clearly.

Licensee Data (To be completed in full by Licensee)		
Name of Licensee:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:	Original Licensure Date:	
Place of Employment During Consultation Period:		

Consultant Data (To be completed in full by Consultant)		
Name of Consultant:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:	Home Telephone:	
Consultant's Education/School:		
Year Graduated	Degree Awarded:	

VERIFICATION OF CONSULTATION FORM

Licensee Consultation Information (To be completed in full by Consultant)	
Total Number of Hours Licensee Worked Per Week	
Total Number of Hours Per Month ***Individual*** Supervision/Consultation Was Given	
Total Number of Hours Per Month ***Group*** Supervision/Consultation Was Given	
Total Number of Hours Licensee Worked During the Period Listed Below	

Dates the Applicant was Under your Supervision: From _____ (month/day/year) To _____ (month/day/year)

1. Please describe licensee's specific functions in terms of social work. If consultation was provided to a Master's level Social Worker, please describe applicant's functions in terms of prevention, diagnosis and treatment of mental illness/disorders and psychosocial treatment:

   _____

   _____

   _____

   _____

2. Please state briefly licensee's personal character, ethical conduct, and competence:

   _____

   _____

3. Do you recommend that this person be re-licensed? [ ] YES [ ] NO
   If not, please describe why:

   _____

   _____

   _____

I ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE TO RETURN THIS FORM TO THE LICENSEE FOR MAILING TO THE BOARD OF SOCIAL WORKER LICENSURE.

Signature of Consultant: _____ Date: _____