

STATE OF MAINE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION **STATE BOARD OF SOCIAL WORKER LICENSURE** OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

VERIFICATION OF CONSULTATION FORM Page 1 of 2

Use a <u>separate form</u> 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 <u>in full</u> 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 <u>in full</u> by Consultant)					
Name of Consultant:		License Number:			
Mailing Address:					
City:	State:		Zip Code:		
Work Telephone:		Home Telephor	ie:		
Consultant's Education/School:					
Year Graduated		Degree Awarde	d:		

VERIFICATION OF CONSULTATION FORM Page 2 of 2

Licensee Consultation Information (To be completed <u>in full</u> by Consultant)						
Period the Applicant was Under your Supervision: From To month/day/year						
Number of Hours Licensee Worked Per Week						
Number of Consultation Hours Licensee received Per Month						
Total Number of Hours Licensee Worked During the Period Listed Above						
Total Individual Consultation Hours Accrued During the Period Listed Above						
Total Group Consultation Hours Accrued During the Period Listed Above						
 Please describe licensee's specific functions in terms of social work. If constructions provided to a Master's level Social Worker, please describe applicant's fund of prevention, diagnosis and treatment of mental illness/disorders and psycoment: 	ctions in terms					
2. Please state briefly licensee's personal character, ethical conduct, and competence:						
3. Do you recommend that this person be re-licensed? [] YES [If not, please describe why:] NO					

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: _____