

BCD Application for Board Certification in Clinical Supervision

First Name _____ M.I. ____ Last Name _____

BCD# (if known) _____

Current Direct Practice

Name of current practice setting/location:

Briefly describe the nature of your clinical supervision by setting, type, and client base (e.g. "In an agency, I supervise three clinical social workers who work primarily with adolescents.")

Use of Consultant

Who is the consultant or member of a peer supervision group advising you on issues related to clinical supervision?

Consultant's Name: _____

Consultant's Advanced Degree: _____

Consultant's Clinical Discipline: _____

Phone (_____) _____ Email _____

[Note: ABE may contact your consultant to verify information.](#)

Register your Evaluators

Please refer to the guidelines in "Qualifications of Your Evaluators", and fill in the information about those whom you choose as evaluators.

Print out two of the "Evaluator Package" forms (separate from this one), then print your name at the top on page one (shaded area) but do not fill out anything else. The evaluations of your practice will be mailed to ABE or returned to you (in a sealed envelope) to mail. Please urge your Evaluators to mail them within two months of your sending this form.

Evaluator #1 must be an advanced Clinical Social Worker (BCD or BCD-eligible) who is a current or former colleague, supervisor, or consultant.

Evaluator's Name: _____

Academic Degree (e.g. MSW): _____ Licensure Initials (e.g. LCSW): _____

Email Address: _____ Day Phone#: (____) _____

Contact dates with your Evaluator:

Start Date: ____/____/____ End Date: ____/____/____
mm yy mm yy (If ongoing, enter current mm/yy)

Evaluator #2 must be an advanced Clinical Social Worker (BCD or BCD-eligible) OR Psychiatrist (M.D. or D.O., board-certified or board-eligible) OR Clinical Psychologist (doctoral level) who is/was a colleague, supervisor, or consultant.

Evaluator's Name: _____

Professional Discipline (CSW, M.D., Psychologist): _____

Academic Degree (e.g. MSW): _____ Licensure Initials (e.g. LCSW): _____

Email Address: _____ Daytime Phone #: (____) _____

Contact Dates with your Evaluator:

Start Date: ____/____/____ End Date: ____/____/____
mm yy mm yy (If ongoing, enter current mm/yy)

Note: If one or both of your Evaluators is found ineligible, you will be contacted with instructions for registering a new Evaluator(s). Remember: you must arrange for your Evaluators to mail their evaluations within two months of your sending this form.

Affirmation

I affirm that I gave "Yes" answers to the four questions in my application, that the information I provided in this application is accurate to the best of my knowledge, and that I currently hold the BCD and am in good standing with my state licensing board (if applicable). As an applicant, I agree that the American Board of Examiners may audit my clinical practice history and continuing education, and that any material omission or misrepresentation by me may be grounds for revocation or suspension of my credential(s).

Signature: _____ Date: ____/____/____
mm dd yyyy

Please provide your preferred mailing address:

Street Address: _____

City/State/Zip: _____

Email Address (required): _____

Application Fee

Payment (\$195): ____ MasterCard ____ VISA ____ AmEx or ____ Check (enclosed, payable to ABE)

Cardholder name: _____

Card #: _____ Card expiration date: ____/____
mm yy

I authorize credit card usage

(Signature): _____

Please follow the instructions below on submitting your application.

American Board of Examiners, Shetland Park, 27 Congress St. #501, Salem, MA 01970 ♦ 1-800-694-7882 (fax)

Congratulations, you have completed your application!

Make sure that you have filled out the Application Kit thoroughly. Missing information will delay the processing of your application!

Please check to see that you have done the following:

- ❑ Made your own copy of the materials you are mailing to us.
- ❑ Mailed or handed "Evaluator Packages" to your Evaluators to complete. They will mail their evaluations to ABE or will return them to you in a sealed envelope.
- ❑ Remember to encourage your Evaluators to send in evaluations A.S.A.P. and certainly within 60 days of mailing your application materials.

Fax your Application Kit to 1-800-694-7882 or mail to:

ABE
Shetland Park
27 Congress St., #501
Salem, MA 01970
Attn: Credentialing Department

Applications are processed as rapidly as possible. Please allow a minimum of three weeks before contacting ABE regarding the status of your application. Your eligibility for review will be determined based on this Application. A \$75 refund of the \$195 application fee will be made to you if found ineligible for this specialty; no refund will be made if you withdraw your application or if your evaluators decide you do not meet standards for board certification.

Questions? Please contact ABE Credentialing at kab@abecsw.org or 1-800-694-5285 x16.

**We wish you success in attaining board certification in
Clinical Supervision**