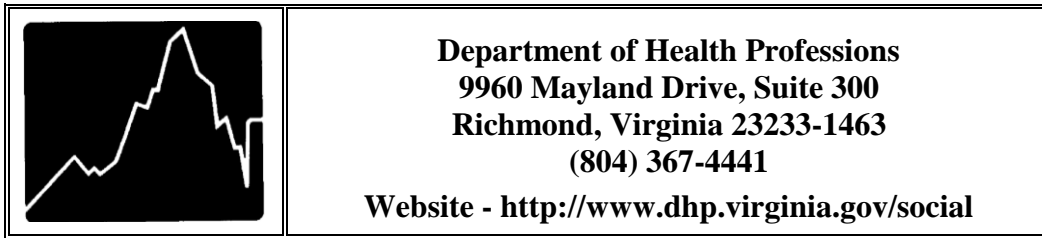


COMMONWEALTH OF VIRGINIA
BOARD OF SOCIAL WORK



GENERAL INFORMATION FOR
REINSTATEMENT FOLLOWING DISCIPLINARY ACTION
AS A SOCIAL WORKER (LSW) OR CLINICAL SOCIAL WORKER (LCSW)

Any person whose license has been suspended, revoked, or denied renewal by the board under the provisions of 18VAC140-20-160 shall, in order to be eligible for reinstatement:

- (i) Submit a new application to the board for a license;
- (ii) Pay the appropriate reinstatement fee; and
- (iii) Submit any other credentials as prescribed by the board.

Submit the application materials in **one** package to the address indicated above. Please review this checklist to make certain that **all** the required documents are submitted.

Application:

- Fee:** A \$500.00 application fee must be paid by check or money order made payable to the “Treasurer of Virginia”. This fee is non-refundable and non-transferable.

Supporting Documentation:


Upon completion of the reinstatement application you will be required to submit to the Board office the following items in a single packet:

- Out-of-State Licensure Verification:** If you have ever held a licensure or certification to practice social work, *whether current or expired*, please send the enclosed verification form to the issuing jurisdiction. Online verifications may be accepted if printed within the past six (6) months.

Following the receipt of your reinstatement application, an administrative proceeding will be scheduled. After a hearing, the board may, at its discretion, grant the reinstatement.

Please read the Regulations carefully before completing your application for reinstatement.

**COMMONWEALTH OF VIRGINIA
BOARD OF SOCIAL WORK**

	<p>Department of Health Professions 9960 Mayland Drive, Suite 300 Richmond, Virginia 23233-1463 (804) 367-4441</p> <p>Website - http://www.dhp.virginia.gov/social</p>
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REINSTATEMENT FOLLOWING DISCIPLINARY ACTION
AS A SOCIAL WORKER (LSW) OR CLINICAL SOCIAL WORKER (LCSW)

I hereby submit an application for reinstatement of my Virginia license number _____.

INSTRUCTIONS	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK		
<u>Applicant must complete all sections.</u>				
I. GENERAL INFORMATION				
Name (Last, First)	(Middle Initial)	(Maiden*)	(Suffix)	
Social Security Number or Virginia DMV Control Number**		Date of Birth (MM/DD/YY) / /		
Mailing Address (Street and/or Box Number, City, State, Zip Code)		Home Telephone Number		
Public Address (Street and/or Box Number, City, State, Zip Code)***		Alternate Telephone Number		
E-mail Address				
LICENSURE/CERTIFICATION – List in order of attainment all the states in which you now hold or have ever held an occupational license or certificate to practice as a social worker in order of attainment. For each license or certificate indicated below, whether current or lapsed, you must submit a Verification of Licensure form completed by the issuing jurisdiction.				
STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	TYPE OF LICENSE/CERTIFICATE	STATUS
				<input type="checkbox"/> Active <input type="checkbox"/> Expired <input type="checkbox"/> Other
				<input type="checkbox"/> Active <input type="checkbox"/> Expired <input type="checkbox"/> Other
				<input type="checkbox"/> Active <input type="checkbox"/> Expired <input type="checkbox"/> Other

***Name change:** Documentation must be provided to show name change(s) if name has ever been changed from the time you attended school or while you were licensed in other jurisdictions. Photocopies of marriage licenses or court orders are accepted.

In accordance with § 54.1-116 of the *Code of Virginia*, you are required to submit your **Social Security Number or your control number issued by the Virginia Department of Motor Vehicles.

*****Licensure Address is Public Information and Published on the Internet.**

COMPETENCIES – Regulation 18VAC140-20-150.B., states that licensees may practice only within the competency areas for which they are qualified by education and experience.

Provide the client population you work with or intend to work with and clinical skills you will use in doing so (skills from MSW training). *If requested by the board, this information must be supported by documentation of training or education.*

(Use additional paper, if necessary.)

<u>Client Population</u>	<u>Clinical Skills to be Used</u>
<input type="checkbox"/> Children <input type="checkbox"/> Couples <input type="checkbox"/> Adolescents <input type="checkbox"/> Families <input type="checkbox"/> Adults <input type="checkbox"/> Elderly <input type="checkbox"/> Military <input type="checkbox"/> Other: (Specify) <div style="text-align: center; border-bottom: 1px solid black; width: 100px; margin-left: auto; margin-right: auto;"></div>	

ANSWER THE FOLLOWING QUESTIONS:	YES	NO
<p>1. Have you ever been denied the privilege of taking an occupational licensure or certification examination? If yes, state what type of occupational examination and where:</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail on a separate sheet of paper.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. Have you ever been convicted of a violation of or pled nolo contendere to any federal, state, or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations and driving under the influence.) If yes, explain in detail on a separate sheet of paper and provide court documents.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>4. In the last twelve (12) months, have you been unable to practice social work by reason of excessive use of alcohol, drugs, chemicals or any other type of material or as a result of any mental or physical condition? If yes, please provide an explanation on a separate sheet of paper.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>5. Have you ever been censored, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper.</p>	<input type="checkbox"/>	<input type="checkbox"/>

IV. PROFESSIONAL EMPLOYMENT EXPERIENCE

List in chronological order the entire professional employment experience you have had after receiving your master's degree in Clinical Social Work. List present position first and date back to your master's degree. (Use additional paper, if necessary.)

Employer's Name and Address:

Total Number of Work Hours per Week:	Total Number of Hours per Week in "Clinical Social Work Services"	Dates of Employment	
		From (MM/YY)	To (MM/YY)

Applicant's Job Title:

Duties Performed:

Employer's Name and Address:

Total Number of Work Hours per Week:	Total Number of Hours per Week in "Clinical Social Work Services"	Dates of Employment	
		From (MM/YY)	To (MM/YY)

Applicant's Job Title:

Duties Performed:

Employer's Name and Address:

Total Number of Work Hours per Week:	Total Number of Hours per Week in "Clinical Social Work Services"	Dates of Employment	
		From (MM/YY)	To (MM/YY)

Applicant's Job Title:

Duties Performed:

The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.

**AFFIDAVIT
(To be completed before a notary public)**

State of _____ County/City of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a clinical social worker in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Signature of Applicant

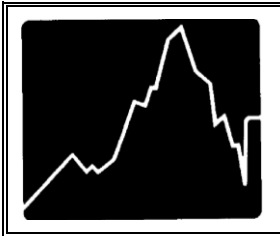
Subscribed to and sworn to before me this _____ day of _____, 20_____.

Signature of Notary Public

My commission expires _____ day of _____, 20_____.

SEAL

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BOARD OF SOCIAL WORK**



**Department of Health Professions
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463
(804) 367-4441**

Website: <http://www.dhp.virginia.gov/social>

APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

To be completed by applicant:

Last Name _____	First Name _____	M.I. _____
Address _____		
City _____	State _____	Zip Code _____
Home Phone Number _____	Work Number _____	
Email Address _____		

To be completed by state Board of Social Work:

Title of License _____	License Number _____		
Issue Date _____	Expiration Date _____		
<input type="checkbox"/> By Examination	<input type="checkbox"/> By Waiver	<input type="checkbox"/> By Endorsement	<input type="checkbox"/> Reciprocity
Is there any public information relating to this license?			
<input type="checkbox"/> Yes (specify details on a separate sheet)		<input type="checkbox"/> No	
Certification by the authorized Licensure Official of the State of _____			
I certify that the information is correct.			
Authorized Licensure Official Name and Title _____			
State Seal	Title of Board _____		
	Telephone Number _____		
	Email Address _____		
	Date _____		