Clinical Supervision Hours Tracking Log

For Supervised Clinical Practice Hours Toward the Illinois LCSW License

COMPLETE MONTHLY

THIS FORM IS NOT REQUIRED BY IDFPR. Its purpose is to assist the supervisee and supervisor as they keep track of the hours that qualify for the supervisee's supervised clinical practice experience. This form is organized according to the IDFPR VE-SW Form (Verification of Employment /Experience Form) which is the required form the supervisor must complete for the supervisee to submit along with their Illinois LCSW license application upon completion of supervision.

Month/Year: _____

Name of Supervisee: _____ Job title: _____

Supervisor Name: _____

Supervisor LCSW License number: _____ License State: _____ Date License Awarded: _____

Name of and Address of Worksite: _____

Total number of clinical work hours acquired this month (maximum of 40hr/week): _____

Date of Supervision:_____ Choose or Circle One: ☐Individual or ☐Group

Length of supervision: _____

Date of Supervision:_____ Choose or Circle One: ☐Individual or ☐Group

Length of supervision: _____

Date of Supervision: _____ Choose or Circle One: ☐Individual or ☐Group

Length of supervision: _____

Date of Supervision:_____ Choose or Circle One: ☐Individual or ☐Group

Length of supervision: _____

Total hours of supervision this month (state requires minimum of 4 hours): _____

The applicant's performance was satisfactory or better (Choose or circle answer): ☐YES / ☐NO

The above indicated clinical experience has been documented by myself and has been performed by the applicant pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

Name of Supervisor: _____ Supervisor Signature:_____ Date: _____

FOR SUPERVISEE USE ONLY:

Total acquired hours _____ out of 3,000 (for MSW) or 2,000 (for DSW)

Add total hours for this month and all previous hours from prior months.

nasw
ILLINOIS CHAPTER