

VII To assist with recruitment, please explain why you are joining NYSSCSW and how you heard about us:

VIII Affirmation: I affirm that the information detailed here is a true account of my training and experience.
I agree to be bound by the NYSSCSW Code of Ethics.

Signature: _____ Date: _____

APPLICANTS APPLYING FOR FELLOW STATUS ONLY

A. Post-Master's Clinical Training: (indicate either a certification from an institute or details of 75 hours Post Master's coursework, not including workshops, seminars, or conferences.)

School	Address	Dates	Course or Certificate
1. _____			
2. _____			
3. _____			

B. Supervision: (Complete only if you do not have the "R" Credential from NYS)

Name	Institution or Professional Affiliation	Dates	Total # Hours
1. _____			
2. _____			
3. _____			

C. If you do not have the "R" or "BCD" have you had personal analysis or psychotherapy? Yes No

Date Begun	Date Ended	#Hours/Week
_____	_____	_____

ALL APPLICANTS

Please make checks payable to New York State Society for Clinical Social Work and mail with the completed form to
243 Fifth Ave., Suite 324, New York, NY 10016-8703

An application using a credit card (Visa or Mastercard) may be faxed to 1-718-785-9582.

Name on card: _____

Card number: _____ Expiration Date: _____

* If you do not have someone to join with please contact Rita Smith who will try to pair you with someone from another agency 914-993-0837 Ritascoptionsmith2@verizon.net

PLEASE MAIL COMPLETED FORM & PAYMENT TO ADDRESS AT TOP OF APPLICATION

FOR OFFICE USE ONLY:

MC_____ QB_____ LIST_____ NMK_____ CHPT_____