



Board of Social Work Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

Email: SocialWorkExaminers@Alaska.Gov

Website: ProfessionalLicense.Alaska.Gov/SocialWorkExaminers

Clinical Social Worker License by Credentials Application Instructions

A person may apply for a license to practice clinical social work in the State of Alaska by credentials. There is no temporary license offered for Clinical Social Work.

The Board will issue a license to practice clinical social work to an applicant who holds a current license to practice clinical social work in another jurisdiction that, at the time of original issuance of the license, had requirements for licensure equal to or more stringent than those of this state. (See AS 08.95.120)

The following must be received by the division before your application for Clinical Social Worker License by Credentials can be reviewed:

1. APPLICATION

A signed, completed application (#08-4871, pages 1-4).

2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee: \$100.00

Initial License Fee: \$325.00

Total Fees Due: \$425.00

3. AUTHORIZATION FOR RELEASE OF RECORDS

A completed Authorization for Release of Records form (#08-4871a).

4. VERIFICATION OF LICENSURE

A completed Verification of Licensure form (#08-4871b) from each state, except Alaska, where you are currently or have previously been licensed, even if the license held was not equivalent to the license for which you are currently applying. The state must verify any disciplinary actions taken.

THE EXAMINATION TAKEN MUST BE THE CLINICAL LEVEL EXAMINATION OFFERED BY THE ASSOCIATION OF SOCIAL WORK BOARDS. (Make copies of #08-4871b to request multiple license verifications.)

5. PROFESSIONAL REFERENCES

Three professional references (form 08-4871c) from the following, as appropriate:

- a. a reference from a current employer supervisor where employed to practice social work;
- b. a reference from a previous employer supervisor where employed to practice social work,
- and -
- c. a reference from any one of the following professionals:
 - Master's or doctorate degree social worker;
 - Licensed psychological associate, clinical psychologist, or physician specializing in psychiatry;
 - Licensed medical or osteopathic physician;
 - Licensed advanced nurse practitioner with a specialty area of practice in mental health;
 - Licensed registered nurse with a master's degree in psychiatric nursing;
 - Licensed marriage and family therapist; or
 - Licensed professional counselor.

Note: If you do not have a current/previous supervisor, please provide a letter of explanation regarding any missing reference.

6. CONTINUING COMPETENCY

To meet the continuing competency requirements of 12 AAC 18.112 you must verify:

- a. successful passage of the Clinical level examination within the two years before making application (you must request exam scores from ASWB at www.aswb.org).

- OR -

- b. verification of completion of 1,500 hours of work as a social worker at the same level within the five years immediately preceding the application (form 08-4871d);

- and -

- c. completion of the continuing education (CE) requirements in 12 AAC 18.210 (a)(1), (3), (4), and (5). The required 45 hours of CEs must have been obtained during the past five years before the date the application is received. Of the 45 hours of CE required, a minimum of six contact hours in substance abuse education, three contact hours in professional ethics, three contact hours in teletherapy practice, and three contact hours in suicide education is required. (Use form #08-4871e – You must attach course certificate indicating attendance and number of CE hours received.)

An incomplete application or any unusual circumstances noted in the application may require additional processing time. While we understand your desire to conclude this process as quickly as possible, our licensing staff is responsible for reviewing many files and cannot complete the application process if required documents are missing. It is your responsibility to ensure required documents are submitted to our office.

The application review process is defined by the requirements set forth in state law. The Division must comply with those laws in processing applications. The Division conducts a thorough evaluation of education, training, employment or work history, malpractice history and any criminal or disciplinary history. We recommend you do not make commitments for loans, practice start dates, home purchases, etc., based on the expectation of licensure. The Division will not accelerate one application over another, nor will it forego any elements of its screening process.

General Information

APPLICATION PROCESSING:

The average time to process a paper application varies by program but can take several weeks from the date it is received in this office complete with all correct forms, supporting documents and appropriate fees paid. When the application is complete and correct, and all supporting documents have been received and all fees have been paid, the license will be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

LICENSE TERM:

There is no "inactive" status. If you choose not to renew your license, it will lapse. Licenses are issued for a two-year period and expire on June 30 of even-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date are issued to the next biennial expiration date. Renewal applications become available 30-90 days prior to the expiration date. One renewal notice will be sent via email or mail at least 30 days before license expiration to the last known email or mailing address of record. Failure to receive a renewal notice does not alleviate the requirement to renew the license if you wish to continue providing services in Alaska.

PROFESSIONAL FITNESS QUESTIONS:

A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions in the application, be sure to submit a signed and dated explanation, and the charging document and judgement.

DENIAL OF APPLICATION:

Please be aware that the denial of an application of licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

RANDOM AUDIT:

If your program requires continuing education, the Division will audit a percentage of the license renewals. If your license is randomly selected for audit, a letter will be sent with instructions to submit documentation as proof you satisfied the continuing competency requirements as stated on this renewal form. Licensees are randomly selected by computer and may be randomly selected as often as the computer program chooses. You must save your documents for at least four years so you can respond to audits.

ADDRESS OR NAME CHANGE:

In accordance with 12 AAC 02.900, it is the applicant's/licensee's responsibility to notify the Division, in writing, of changes of address or name. Name and address change notification forms are available on the Division's website. The address of record with the division will be used to send renewals and all other official notifications and correspondence. The name appearing on the license must be your current legal name.

CERTIFIED TRUE COPIES:

If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:

AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed for an individual. If you do not have a U.S. Social Security Number, please complete the Request for Exemption from Social Security Number Requirement form (#08-4372) located at *ProfessionalLicense.Alaska.Gov* or contact the division for a copy of the form. This form is required with every application if you do not have a U.S. Social Security Number.

PUBLIC INFORMATION:

Please be aware that all information on the application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at *ProfessionalLicense.Alaska.Gov* under License Search.

ABANDONED APPLICATIONS:

Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

BUSINESS LICENSES:

The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or *BusinessLicense.Alaska.Gov*.

STALE DOCUMENTS:

Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

PAYMENT OF CHILD SUPPORT:

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

STATUTES AND REGULATIONS:

The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*

If you would like to receive notice of all proposed regulation changes for your program, please send a request in writing with your name, preferred contact method (mail or email), and the specific program you want to be updated on to the address below.

Regulations Specialist
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
EMAIL: *RegulationsAndPublicComment@Alaska.Gov*



THE STATE
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CSW

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Clinical Social Worker License by Credentials Application

PART I Payment of Fees

| | | |
|-----------------------|--|-----------------|
| Required Fees: | <input type="checkbox"/> Nonrefundable Application Fee | \$100.00 |
| | <input type="checkbox"/> Initial License Fee | \$325.00 |

PART II Personal Information

| | | | |
|---|--------------------|-----------------------|---|
| Full Legal Name: | | | |
| <p>Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Other Names Used: _____</p> | | | |
| Mailing Address: | P.O. Box or Street | City | State Zip |
| Contact Phone: | | Date of Birth: | |
| <p>EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.</p> | | | |
| Email Address: | | Select One: | <input type="checkbox"/> Send my Correspondence Electronically <input type="checkbox"/> Send my Correspondence by Mail |
| <p>Note: If both boxes are selected above, you will receive correspondence electronically.</p> | | | |
| <p>SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.</p> | | | |

PART III Education

List the name & address of the Master's Social Work program attended and ANY other education programs attended.

| Name of College | Address | Degree Awarded | Date Awarded |
|-----------------|---------|----------------|--------------|
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PART IV Examination Information

Have you successfully completed the ASWB's social work examination at the Clinical level?

- No
 Yes

| | | | |
|-----------------------|--|-------------------|------------|
| State of Exam: | | Exam Date: | mm/dd/yyyy |
|-----------------------|--|-------------------|------------|

PART V Current License Information

To apply for licensure by CREDENTIALS, please list the state license your application is based on.

| | | | |
|-------------------------|--|-------------------------|--|
| State of Issue: | | License Number: | |
| Type of License: | | | |
| Issue Date: | | Expiration Date: | |

PART VI Professional License(s)

Chronologically list every state, U.S. jurisdiction, or country where you currently hold, or have ever held a license or certification. Please indicate whether certified or licensed. If you need additional pages, please attach.

Check here if none.

| State or Jurisdiction | License Number | License Type | Initial Issue Date | Expiration Date |
|-----------------------|----------------|--------------|--------------------|-----------------|
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PART VII Professional Fitness Questions

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

When in doubt, disclose and explain.

1. Have you ever been disciplined by any state board for any violation of the Social Work Practice Act or unethical conduct? Yes No

2. Have you ever had an application for a professional license denied? Yes No

3. Have you ever had a license to practice social work revoked, suspended, restricted, or limited? Yes No

4. Have you ever been investigated by a licensing authority or professional association even if no disciplinary action resulted? Yes No

5. Have you ever had any malpractice settlements or judgments paid on your behalf? Yes No

6. Have you been convicted of a criminal offense other than a minor traffic violation? Yes No

7. Are you now or have you been, within the past 5 years, addicted to or excessively used or misused alcohol, narcotics, barbiturates, or habit-forming drugs which may impair or interfere with your ability to practice social work? Yes No

8. Are you now or within the past 5 years, been treated or hospitalized for emotional or mental illness, drug addiction or alcoholism which may impair or interfere with your ability to practice social work? Yes No

"Yes" Answers

If you answered "yes" to questions 7 or 8, in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice Social Work. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.



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Signature Page

Applicant Name:

PART VIII Agreement

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license, certificate, or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

Applicant Signature:

Date Signed:



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Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my employment, educational records, and records pertaining to litigation, judgments, suits and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators.

I authorize the division to discuss my records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with the application (initial, renewal, reactivation) for issuance of a clinical social worker license.

I hereby release you, your organization, the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business, and Professional Licensing and its investigators, and all others directly and/or indirectly involved in this matter from any liability or damage which may result from furnishing the information requested.

This authorization expires one (1) year from the date of my signature below.

| | | | |
|----------------------|--------------------|-----------------------|-----------|
| Name: | First | Middle | Last |
| Full Address: | P.O. Box or Street | City | State Zip |
| Phone: | | Date of Birth: | |
| Email: | | | |
| Signature: | | Date: | |



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Verification of Licensure



Applicant:

Please complete the identifying information below and forward a copy of this form to all states, territories, or jurisdictions where you currently are or have ever been licensed. *Make additional copies of this form, as needed.*

| | | | |
|-----------------------------|--|---------------------|--|
| Applicant Name: | | | |
| Applicant Signature: | | Date Signed: | |



Licensing Agency or State Board:

Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Social Work Examiners at the letterhead address.

| | | | |
|---|---|---|--|
| Licensee Name: (As Shown in Your Records) | | State or Jurisdiction: | |
| Degree Awarded: | | License Number: | |
| License Type: | | Licensed By: | <input type="checkbox"/> Credentials <input type="checkbox"/> Exam |
| Exam Administered by ASWB? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Exam: (If Applicable) | |
| Level of Examination: | <input type="checkbox"/> Basic <input type="checkbox"/> Masters <input type="checkbox"/> Clinical | Exam Results: | <input type="checkbox"/> Pass <input type="checkbox"/> Fail |
| Original Issue Date: | | Expiration Date: | |

1. Has the license ever been revoked, suspended, placed on probation, or restricted in any way? Yes No

2. Is the licensee the subject of a pending disciplinary proceeding? Yes No

3. Has the licensee ever been the subject of an unresolved complaint, review procedure, or disciplinary action? Yes No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

| | | | | |
|------------|----------------------|--|---------------------|--|
| Board Seal | Signature: | | Date Signed: | |
| | Printed Name: | | Title: | |
| | Email: | | Phone: | |



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Professional Reference

Three professional references are required: (1) A current employer supervisor where employed to practice social work; (2) A previous employer supervisor where employed to practice social work; and (3) A reference from one of the following professionals:

- (a) Master's or doctorate degree social worker;
- (b) Licensed psychological associate, clinical psychologist, or physician specializing in psychiatry;
- (c) Licensed medical or osteopathic physician;
- (d) Licensed advanced nurse practitioner with a specialty area of practice in mental health;
- (e) Licensed registered nurse with a master's degree in psychiatric nursing;
- (f) Licensed marital and family therapist; **OR**
- (g) Licensed professional counselor.

➔ **Applicant:** Please complete the identifying information below and forward a copy of this form to the appropriate individuals. *Make additional copies of this form, as needed.*

| | | | | |
|-----------------------------|--------------------|---------------------|-------|-----|
| Applicant Name: | | | | |
| Mailing Address: | P.O. Box or Street | City | State | Zip |
| Applicant Signature: | | Date Signed: | | |

➔ **Reference:** Please provide the information requested below for the applicant identified in this form and send document directly to the Alaska Board of Social Work Examiners at the letterhead address.

| | | | | |
|--|--|---|------------|-----|
| Reference Name: | Relationship to Applicant: | | | |
| License Number: | License Type: | | | |
| Name of Institution or Clinic where Employed: | | | | |
| Address: | P.O. Box or Street | City | State | Zip |
| Email Address: | | Phone Number: | | |
| Associated with Applicant from Date: | mm/dd/yyyy | Associated with Applicant to Date: | mm/dd/yyyy | |
| Reference Type: (Check all that apply) | <input type="checkbox"/> Current employer supervisor <input type="checkbox"/> Previous employer supervisor <input type="checkbox"/> Master's degree social worker <input type="checkbox"/> Doctorate degree social worker <input type="checkbox"/> Licensed psychological associate <input type="checkbox"/> Licensed clinical psychologist <input type="checkbox"/> Licensed physician specializing in Psychiatry <input type="checkbox"/> Licensed marriage and family therapist <input type="checkbox"/> Licensed medical physician <input type="checkbox"/> Licensed osteopathic physician <input type="checkbox"/> Licensed professional counselor <input type="checkbox"/> Licensed registered nurse with a master's degree in psychiatric nursing <input type="checkbox"/> Licensed advanced nurse practitioner with specialty area of practice in mental health | | | |

Recommendation

The board believes a license to practice social work at the clinical level carries important responsibilities. Please comment on the applicant's qualifications, abilities, character, etc., which involves use of social work principles and methods, as defined in AS 08.95.990(7), and which include counseling of a nonmedical nature to assist in the treatment of mental and emotional conditions of individuals, families, and groups; providing information and referral services; providing or arranging for the provision of social services; explaining and interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, provide, or improve social and health services; and doing research related to social work.

AS 08.95.990(2) defines "clinical social work" as the diagnosis of psychiatric disorders and the use of techniques of applied psychotherapy of a nonmedical nature while practicing social work.

Comments:

To your knowledge:

- | | | |
|--|------------------------------|-----------------------------|
| 1. is the applicant of good moral character? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. has the applicant within the past five years, ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. has the applicant ever been found guilty of incompetence by another state or jurisdiction? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. has the applicant violated the ethical standards of another state agency or jurisdiction for providers of social work services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. has the applicant misrepresented his or her qualifications to the board in any way? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. has the applicant been sanctioned for practicing social work services without a license? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Would you recommend the applicant for licensure as a clinical social worker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please Explain:

- | | | |
|---|------------------------------|-----------------------------|
| 8. Any further comments the board might consider in reviewing this applicant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

Please Explain:

9. Please evaluate the applicant's technical knowledge and practical experience:

Excellent Very Good Fair Needs Improvement

Signature

I hereby certify that the above information is true and complete to the best of my knowledge.

Reference Printed
Name:

Reference
Signature:

Date Signed:



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Verification of Work Experience

The continuing competency requirements established in 12 AAC 18.112(2)(A) require verification of completion of 1,500 hours of work as a social worker at the same level within the five years immediately preceding the application.

➔ Applicant: Please complete the identifying information below and forward a copy of this form to the appropriate individual(s). Make additional copies of this form, as needed.

Form with fields: Applicant Name, Mailing Address (P.O. Box or Street, City, State, Zip), Applicant Signature, Date Signed.

➔ Employer or Supervisor: Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Social Work Examiners at the letterhead address. Note: DO NOT provide the number of hours worked per week (i.e., 40 hours/week). Forms without the total number of hours during the entire supervised period will not be accepted and will be returned as incomplete.

Form with fields: Employer or Supervisor Name, Name of Institution or Professional Clinic, Phone Number, Address (P.O. Box or Street, City, State, Zip), Email Address, Employment Start Date (mm/dd/yyyy), Employment End Date (mm/dd/yyyy), Total Number of Hours (Must be at least 1,500).

1. The board believes a license to practice social work carries important responsibilities. Please comment on the applicant's qualifications, ability, character, etc.

Empty text box for comments.

Signature

Form with fields: I hereby certify that the above information is true and complete to the best of my knowledge., Employer or Supervisor Printed Name, Employer or Supervisor Signature, Date Signed.

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Continuing Education Documentation

Note: If using CEs to meet the continuing competency requirements of 12 AAC 18.112, List the continuing education (CE) requirements per 12 AAC 18.210 (a)(1), (3), (4), and (5). The required 45 hours of CE's must have been obtained during the past five years before the date the application is received. Of the 45 hours of CE required, at least six contact hours must be in substance abuse education, at least three contact hours must be in professional ethics, at least three contact hours must be in teletherapy practice, and at least three contact hours in suicide education. **Attach course certificate(s) indicating attendance and total number of CE hours awarded.**

List only courses that you have taken and completed. Do not list courses you anticipate taking.

- Attach the Certificate of Completion for each course in the order they are listed on the form.
- Courses that do not have a Certificate of Completion will not be counted for credit - see 12 AAC 18.200(3)
- No more than 12 contact hours may be obtained in one day – see 12 AAC 18.210(e).

In the table below, the categories for hours are broken down as follows:

G – General Continuing Education Hours; S – Substance Abuse Hours; P – Professional Ethics; T – Teletherapy Practice, SE – Suicide Education

| | |
|-------------------------|--|
| Registrant Name: | |
|-------------------------|--|

| Dates of Attendance | Course/Seminar or Workshop Title/Brief Description | Principal Instructor | Sponsoring Organization | G | S | P | T | SE |
|---------------------|--|----------------------|-------------------------|---|---|---|---|----|
| | | | | | | | | |
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| Dates of Attendance | Course/Seminar or Workshop Title/Brief Description | Principal Instructor | Sponsoring Organization | G | S | P | T | SE |
|---|--|----------------------|-------------------------|---|---|---|---|----|
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| Subtotal Hours for Each Category: | | | | | | | | |
| Total Hours of Continuing Education: | | | | | | | | |

| | | | |
|--------------------------------|--|---------------------|--|
| Signature | | | |
| Applicant Printed Name: | | | |
| Applicant Signature: | | Date Signed: | |



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Website: ProfessionalLicense.Alaska.Gov

Letter of Explanation for a Professional Fitness “Yes” Answer

Use this form only to explain and document any professional fitness “yes” answers. A “yes” answer is not necessarily disqualifying but concealing one may be.

Each “yes” answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check “yes” to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple “yes” answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a “yes” answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.



Write the professional fitness question number you are answering “yes” to in the box.

| | | | |
|---|--|--------------------------|--|
| Location of Incident: | | Date of Incident: | |
| Explanation of Incident: When in doubt, disclose and explain. <i>Make copies as necessary.</i> | | | |

Did you attach all applicable documents associated with this incident?

- Court Orders
 Consent Agreements
 Disciplinary Actions
 Charging Documents
 Court Records
 Fitness to Practice
 All Other Documentation Related to This Incident
 I have additional incidents for this “yes” answer, or “yes” answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

| | | | |
|-------------------|--|---------------------|--|
| Full Name: | | Program: | |
| Signature: | | Date Signed: | |



THE STATE
of **ALASKA**
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

FOR DIVISION USE ONLY

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Profession Type (e.g., Acupuncture): _____

License Number (if applicable): _____

I wish to make payment by credit card for the following (check all that apply):

AMOUNT

Application Fee: _____

License or Renewal Fee: _____

Other (fine, exam, etc.): _____

1. _____

2. _____

TOTAL: _____

Name (as shown on credit card): _____

Mailing Address: _____

Phone Number: _____ Email (optional): _____

Signature of Credit Card Holder: _____

08-4438

Rev 12/06/2022

Credit Card Payment Form (all major cards accepted)

| CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed! | |
|--|--|
| 1. Credit Card Number: _____ | All 3 fields MUST be completed! This section will be destroyed after the payment is processed. |
| 2. Expiration Date: _____ | |
| 3. Security Code: _____ | |