



**Government of the District of Columbia
Department of Health
Health Professional Licensing Administration**



**BOARD OF SOCIAL WORK
NEW LICENSE APPLICATION**

GENERAL INSTRUCTIONS

All applicants must complete every section of this application and submit the original application and all required supporting documents. The fee must be included for this application to be processed. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call HPLA Customer Service at 1-877-672-2174, Monday through Friday, 8:30AM to 4:30PM EST.

SECTION 1. TYPE OF LICENSE

Please mark the type of license for which you are applying.	TOTAL
<input type="checkbox"/> Licensed Social Work Associate (LSWA) Examination	\$230
<input type="checkbox"/> Licensed Social Work Associate (LSWA) Endorsement	\$230
<input type="checkbox"/> Licensed Graduate Social Work (LGSW) Examination	\$230
<input type="checkbox"/> Licensed Graduate Social Work (LGSW) Endorsement	\$230
<input type="checkbox"/> Licensed Independent Social Work (LISW) Examination	\$230
<input type="checkbox"/> Licensed Independent Social Work (LISW) Endorsement	\$230
<input type="checkbox"/> Licensed Independent Clinical Social Work (LICSW) Examination	\$230
<input type="checkbox"/> Licensed Independent Clinical Social Work (LICSW) Endorsement	\$230
<input type="checkbox"/> Criminal Background Check-Call L-1 Enrollment at 1-877-783-4187/ www.L1enrollment.com	
Re-Examination (select one)	
<input type="checkbox"/> LSWA <input type="checkbox"/> LGSW <input type="checkbox"/> LISW <input type="checkbox"/> LICSW	\$85
<input type="checkbox"/> Duplicate Licenses (limit 5) _____ X \$34.00 =	\$ _____ .00
Total Enclosed	\$ _____ .00

Make check or money order payable to DC Treasurer
*A charge of \$65.00 will be imposed for dishonored checks
(Public Law 89-208)*

MAIL TO:

D.C. Board of Social Work
P.O. Box 37802
Washington, D.C. 20013

HPLA ONLY		
Check \$	Check #	Staff
\$ _____ .00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, you must provide a copy of legal name change document for EACH time that it has changed. Acceptable documents are marriage certificates, divorce decrees or court orders. Complete Section 4 on page 2 of this application.

FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)

SOCIAL SECURITY NUMBER										

M	M	D	D	Y	Y	Y	Y	DATE OF BIRTH												

If applicant does not provide a social security number, a sworn affidavit is required

PLACE OF BIRTH	<input type="checkbox"/>	Male	<input type="checkbox"/>	Female
Provide City and State for US birthplace or Country for foreign place of birth.	GENDER Please check the correct box.			

SECTION 3A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

<input type="checkbox"/>	APARTMENT	<input type="checkbox"/>	SUITE	<input type="checkbox"/>	FLOOR	<input type="checkbox"/>	PO BOX NUMBER	
HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)								
HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)								
CITY	STATE		ZIP CODE + 4					
HOME PHONE NUMBER				HOME FAX NUMBER				
E-MAIL ADDRESS								

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION
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SECTION 3B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME _____

APARTMENT SUITE FLOOR PO BOX NUMBER _____

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME) _____

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME) _____

CITY _____

STATE _____ ZIP CODE + 4 _____

BUSINESS PHONE NUMBER _____ BUSINESS FAX NUMBER _____ E-MAIL ADDRESS _____

SECTION 3C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

HOME BUSINESS

SECTION 4. PREVIOUS NAMES

If your name has changed at any point since you have first taken any exams or attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____
(Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____
(Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____
(Jr, Sr, etc.)

SECTION 5. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the Board of Social Work. Keep a photocopy of all supporting documents for your records.

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	YES	NO	HPLA ONLY
A. Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. <i>The photos must be original photos and cannot be computer-generated copies or paper copies.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Three (3) character reference forms, a minimum of two (2) must be professional references.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Verification(s) of licensure – These should be provided in a sealed envelope from the issuing jurisdiction for each license identified in Section 6B on this page.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Degree in Social Work Transcript – This should be provided in a sealed envelope from the issuing institution for each school listed in Section 6A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. LISW, LICSW EXAMINATION ONLY – Supervision Verification Forms for a minimum of 3,000 work experience hours for the Companies or Agencies identified on the Applicant Post Graduate Work Experience Form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Foreign Trained Applicants – A certification of education from the Foreign Equivalency Determination Service of the Council on Social Work Education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Copy of current license. ENDORESEMENT APPLICANTS ONLY			
H. ENDORESEMENT APPLICANTS ONLY: Examination scores – An original copy or score transfer must be provided. Month and Year of applicable exam _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION
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SECTION 6A. SOCIAL WORK EDUCATION

List all colleges and universities from which you obtained your social work degree. You need only to list the degree that applies to the license level for which you are applying.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

SECTION 6B. SOCIAL WORK LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a social work license. You must request verification of licensure for all of these licenses, past and/or present. You must provide verification for all social work licenses held, past or present.

Jurisdiction	Date License Was First Obtained	License Number

SECTION 6C. SCORE TRANSFER INFORMATION

If you did not take the ASWB exam in the District of Columbia, you will need to transfer your test score to the District of Columbia. This process is handled by the Association of State Social Work Boards (ASWB). Please refer to the AWSB website at www.aswb.org to complete an online score transfer request form. You can also request a score transfer via telephone using a MasterCard, VISA, or Discover credit card. Call (888) 579-3926.

PLEASE NOTE – The DC Board of Social Work does not have reciprocity with any jurisdiction. Licensure in the District of Columbia will not be granted on the basis of licensure in another state. Applicants must apply for licensure in the District and meet all of the District’s social work licensing requirements. The DC Board of Social Work does not grandfather or waiver license requirements. *Fee is subject to change.

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General’s hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General’s website at oig.dc.gov.

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SECTION 7. SCREENING QUESTIONS – Applicants MUST answer all of the following questions.

Applicants must complete all questions by placing an “X” in the appropriate boxes. *If your answer “Yes” to any of the questions A through J below, you must provide full information and complete details on a separate sheet of paper including copies of relevant court documents and attach with this application form.*

**HPLA
ONLY**

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER “YES” TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following: Yes No

- A.
1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
 4. Past due taxes;
 5. Past due District of Columbia Water and Sewer Authority service fees; or
 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et

YES NO

B.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Have you ever been convicted or arrested for a crime (other than minor traffic violations)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
D.	Are you now or have you ever been licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete Section 6B of this form.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
E.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
F.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
G.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
H.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
I.	(Please answer with respect to D.C. or any other state/jurisdiction) (1) Have you withdrawn an application to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charge(s) or investigation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

LISW AND LICSW APPLICANTS – Be sure to complete the Applicant Post Graduate Work Experience Form and the DC Social Work Supervision Calculation Worksheet.

SECTION 8. APPLICANT AFFIDAVIT

This form will be returned unprocessed if the form is not signed by the applicant. Keep a photocopy of this form for your records.

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

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LICENSEE SIGNATURE

NAME (Please Print)

DATE