INSTRUCTIONS FOR REINSTATEMENT AS A SOCIAL WORKER (LSW) OR CLINICAL SOCIAL WORKER (LCSW)

Application:
- **Fee**: A fee of $195.00 for LCSW applicants and $135.00 for LSW applicants must be paid by check or money order made payable to the “Treasurer of Virginia”. This fee is non-refundable. The application can be used for one year from date of receipt.

Supporting Documentation:
Upon completion of the reinstatement application you will be required to submit to the Board the following items:

- **Out-of-State Licensure Verification**: If you have ever held any other health or mental health licensure and/or certification, please send the enclosed verification form to the issuing jurisdiction. This verification is to be completed by the issuing jurisdiction and should be included in your application packet. Verifications older than six months will not be accepted.
  - Online verifications will be accepted; however online verifications must include the name of licensee, title of license, license number, issue and expiration date, and if there is any public information related to the license/certificate.

- **Continuing Education (CE) Certificates**:
  - *Licensed Social Workers (LSW)* will be required to submit a minimum of 30 CE hours including four (4) hours that pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia;
  - *Licensed Clinical Social Workers (LCSW)* will be required to submit a minimum of 60 hours of CE including four (4) hours that pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia.

- **Evidence of Competency**: An applicant for reinstatement shall also provide evidence of competency to practice by documenting one of the following using the enclosed form:
  - (i.) Active practice in another U.S. jurisdiction for at least 24 out of the past 60 months immediately preceding application;
  - (ii.) Active practice in an exempt setting for at least 24 out of the past 60 months immediately preceding application; or
  - (iii.) Practice as a supervisee under supervision for at least 360 hours in the 12 months immediately preceding licensure in Virginia.
COMMONWEALTH OF VIRGINIA
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

REINSTATEMENT
SOCIAL WORKER (LSW) OR CLINICAL SOCIAL WORKER (LCSW)

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

<table>
<thead>
<tr>
<th>INSTRUCTIONS</th>
<th>PLEASE TYPE OR PRINT CLEARLY</th>
<th>USE BLUE OR BLACK INK</th>
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</thead>
<tbody>
<tr>
<td>Applicant must complete all sections.</td>
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GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Applicant (Last, First)</th>
<th>Middle Initial</th>
<th>Maiden Name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number or Virginia DMV Control Number*</td>
<td>Date of Birth (MM/DD/YY)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address (Street and/or Box Number, City, State, Zip Code)</td>
<td>Home Telephone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Address (Street and/or Box Number, City, State, Zip Code)**</td>
<td>Alternate Telephone Number</td>
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<tr>
<td>E-mail Address</td>
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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.

<table>
<thead>
<tr>
<th>STATE</th>
<th>LICENSE/CERTIFICATE NUMBER</th>
<th>ISSUE DATE</th>
<th>TYPE OF LICENSE/CERTIFICATE</th>
</tr>
</thead>
</table>

*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.
### ANSWER THE FOLLOWING QUESTIONS:

1. **Have you ever been denied the privilege of taking an occupational licensure or certification examination?**
   - [ ] Yes
   - [ ] No

2. **Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending?**
   - [ ] Yes
   - [ ] No

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.)**
   - [ ] Yes
   - [ ] No

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?**
   - [ ] Yes
   - [ ] No

5. **Have you ever been censored, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice?**
   - [ ] Yes
   - [ ] No

6. **Are you the respondent in any pending or unresolved board action in another jurisdiction or in a malpractice claim?**
   - [ ] Yes
   - [ ] No

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### 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 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**
COMMONWEALTH OF VIRGINIA
BOARD OF SOCIAL WORK

Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, 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 _____________________________________

☐ By Examination ☐ By Waiver ☐ By Endorsement ☐ Reciprocity

Is there any public information relating to this license?

☐ Yes (specify details on a separate sheet) ☐ 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 ________________________________________________

Revised 08/2016 – Paper Application for Reinstatement
**EVIDENCE OF COMPETENCY TO PRACTICE**

**To be completed by applicant:**

<table>
<thead>
<tr>
<th>I, __________________________________________________, hereby authorize past and present employers, businesses, (Printed Name of Applicant) professional associates and person references to release to the Virginia Board of Social Work (“Board”) any information requested by the Board in connection with the processing of my application.</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________________________</td>
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<tr>
<td>Signature of Applicant</td>
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</table>

**To be completed by reference:**

<table>
<thead>
<tr>
<th>Name of Reference: __________________________ Type of License Held: __________________________</th>
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<tbody>
<tr>
<td>Mailing Address of Reference (Street, and/or Box Number, City, State, Zip Code):</td>
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<tr>
<th>Relationship to Applicant: ________________________________________________</th>
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<tr>
<th>I, __________________________________________________, declare under perjury under the laws of the Commonwealth of Virginia that __________________________, candidate for reinstatement of licensure in the Commonwealth of Virginia was in <strong>active practice in:</strong></th>
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<tbody>
<tr>
<td>☐ another U.S. jurisdiction for at least 24 out of the past 60 months immediately preceding application</td>
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<tr>
<td>☐ an exempt setting for at least 24 out of the past 60 months immediately preceding application</td>
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<td>from __________________________ to __________________________.</td>
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<td>(MM/DD/YY)</td>
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<tr>
<th>__________________________</th>
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</thead>
<tbody>
<tr>
<td>Signature of Reference</td>
<td>Date</td>
</tr>
</tbody>
</table>