American Board of Examiners in Clinical Social Work
Verification Request Form

1) Fill out and return the form below.

2) The fee is $20 per practitioner due at the time of verification. We accept checks or credit card payments.

Name of Company Requesting Verification:

____ Date: _________________

Address:_______________________________________

____

____

Name of Company Employee Requesting Verification:

____

Phone: _______________________________________

Fax: _______________________________________

E-mail: _______________________________________

Name of Practitioner*:

____ BCD# ____________________

Address _____________________________________ DOB ____________________

_____________________________________ SS# ____________________

*The more information provided, the better we can provide verification (e.g. 2 practitioners with the same name in our database require differentiating data).

Payment Method:

Check ○ Name___________________________________

Credit Card: Card No.________________________________

Mastercard ○ Expiration Date___________________________

Visa ○ Signature_______________________________

AMEX ○ Total___________________________________

E-mail: gbooth@centercsw.org Fax: 781-639-5278 Phone: 800-694-5285 ext.10