American Board of Examiners in Clinical Social Work
Verification Request Form

1. Fill out and return the form below.
2. The fee is $25 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: _____

_____

*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: atagliamonte@abecsw.org Fax: 781-639-5278 Phone: 800-694-5285 ext. 10