

**THE PSCSW AWARDS FOR CLINICAL EXCELLENCE
APPLICATION FORM**

Name: _____

Address: _____

Home/Cell Phone: _____ **Phone:** _____

Email: _____

Title of Paper: _____

Name of Clinical Practice Professor and/or Sponsoring Professor:

Email of Clinical Practice Professor and/or Sponsoring Professor:

Field Placement:

Address: _____

Phone: _____

Supervisor's Name: _____

Supervisor's Email: _____

I affirm that I am a graduating MSW/MSS Student: _____ (initial)

I understand that the award is contingent upon my attendance at the PSCSW Annual Meeting,
held on a Sunday afternoon in late fall: _____ (initial)

Religious conflicts which prevent attendance will be honored.