



Secretary of State

Office of Professional Regulation

SOCIAL WORKER

Disclosure Document for Clinical Social Workers

First Name <u>Angela</u>	Middle Initial <u>M</u>	Last Name <u>Rowan</u>
		License # <u>VT LICSW 089.0125095</u>
Previous Name(s) (Maiden) <u>Snyder</u>		


Formal Education	Name of Institution:	<u>Smith College School for Social Work</u>	
	Dates Attended:	<u>6/4/1999 - 8/17/2001</u>	
	Degree(s) awarded, if any:	<u>MSW - Clinical Social Work</u>	
Formal Education	Name of Institution:	<u>Bard College</u>	
	Dates Attended:	<u>8/1/91 - 5/31/95</u>	
	Degree(s) awarded, if any:	<u>BA - Psychology & Gender Studies</u>	
Experience	Description of Practice:	<u>Anna Marsh Clinic, Brattleboro Retreat</u>	
	Location: City/State/Zip	<u>Brattleboro VT 05302</u>	
	Duration:	<u>01/05/2026 - 1/1/</u>	
	Status:	<input checked="" type="radio"/> Full-Time	<input type="radio"/> Part-Time
	Receive supervision or peer consultation?	<input checked="" type="radio"/> YES	<input type="radio"/> NO
	How often?	<u>Weekly</u>	
Experience	Description of Practice:	<u>Angela Rowan, LICSW, LLC</u>	
	Location: City/State/Zip	<u>Greenfield, MA 01301</u>	
	Duration:	<u>09/01/2021 - 12/19/2025</u>	
	Status:	<input checked="" type="radio"/> Full-Time	<input type="radio"/> Part-Time
	Receive supervision or peer consultation?	<input checked="" type="radio"/> YES	<input type="radio"/> NO
	How often?	<u>As needed</u>	
Experience	Description of Practice:	<u>Brattleboro Retreat - Manager DBT Services + Senior Clinical Program Consultant</u>	
	Location: City/State/Zip	<u>Brattleboro, VT 05302</u>	
	Duration:	<u>11/01/2016 - 7/30/2021</u>	
	Status:	<input checked="" type="radio"/> Full-Time	<input type="radio"/> Part-Time

	Receive supervision or peer consultation?	<u>YES</u>	NO
	How often?	As needed	

Scope of Practice	Therapeutic Orientation:	Integrative, CBT, ACT, DBT
	Area of Specialization:	Eating Disorders, Gender-affirming, Adolescents,
	Treatment Methods:	Individual, Group, + Family therapy
	Special Qualifications:	DBT trained

Client's Disclosure Confirmation

My signature acknowledges that I have been given the professional qualifications and experience of (Name, Name), a listing of actions that constitute unprofessional conduct according to Vermont statutes, and the method for making a consumer inquiry or filing a complaint with the Office of Professional Regulation. This information was given to me no later than my third office visit.

Client's Signature or Parent/Guardian	Date
	01/19/2026
Practitioner's Signature	Date