



Secretary of State

Office of Professional Regulation

SOCIAL WORKER

Disclosure Document for Clinical Social Workers

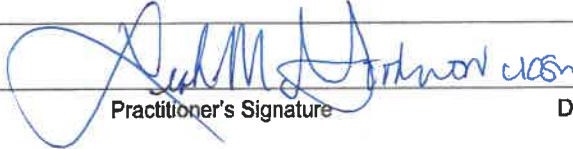
First Name	Middle Initial	Last Name
LEAH	M	GOODNOW
Previous Name(s) (Maiden)		License # 089.0136816

Formal Education	Name of Institution:	COLUMBIA UNIVERSITY OF SOCIAL WORK
	Dates Attended:	8 / / 2004 - 10 / / 2005
	Degree(s) awarded, if any:	MSW
Formal Education	Name of Institution:	WEST CHESTER UNIVERSITY OF PENNSYLVANIA
	Dates Attended:	1 / / 2000 - 5 / / 2003
	Degree(s) awarded, if any:	BSW
Experience	Description of Practice:	BEHAVIORAL HEALTH CRISIS CLINICIAN
	Location: City/State/Zip	BRYN MAWR PA 19010
	Duration:	105 / / 2017 - 10 / / 2025
	Status:	<input checked="" type="radio"/> Full-Time <input type="radio"/> Part-Time
	Receive supervision or peer consultation?	YES <input type="radio"/> NO <input checked="" type="radio"/>
	How often?	
Experience	Description of Practice:	EMERGENCY ROOM SOCIALWORKER
	Location: City/State/Zip	PHILADELPHIA PA
	Duration:	/ / 2009 - 9 / / 2017
	Status:	<input checked="" type="radio"/> Full-Time <input type="radio"/> Part-Time
	Receive supervision or peer consultation?	YES <input type="radio"/> NO <input checked="" type="radio"/>
	How often?	
Experience	Description of Practice:	
	Location: City/State/Zip	
	Duration:	/ / - / /
	Status:	<input type="radio"/> Full-Time <input type="radio"/> Part-Time

	Receive supervision or peer consultation?	YES	NO
	How often?		

Scope of Practice	Therapeutic Orientation:	
	Area of Specialization:	
	Treatment Methods:	
	Special Qualifications:	

**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
	1/20/20
Practitioner's Signature	Date