Secretary of State

Office of Professional Regulation

SOCIAL WORKER

Disclosure Document for Clinical Social Workers

First Name	Ana	Middle Initial	Last Name	Sherwood
			License #	.089.0137049 PROV
Previous Name(s) (Maiden)				

Formal Education	Name of Institution:	Smith College
	Dates Attended:	6/__/22 - 8/__/23
	Degree(s) awarded, if any:	Masters in Social Work
Formal Education	Name of Institution:	Skidmore College
	Dates Attended:	__/__/__ - 5/__/22
	Degree(s) awarded, if any:	Bachelors in Social Work
Experience	Description of Practice:	Group private practice
	Location: City/State/Zip	Amherst, MA
	Duration:	9/__/23 - 9/__/25
	Status:	(Full-Time) Part-Time
	Receive supervision or peer consultation?	(YES) NO
	How often?	Weekly
Experience	Description of Practice:	
	Location: City/State/Zip	
	Duration:	__/__/__ - __/__/__
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	YES NO
	How often?	
Experience	Description of Practice:	
	Location: City/State/Zip	
	Duration:	__/__/__ - __/__/__
	Status:	Full-Time 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

Practitioner's Signature Date 4/14/26