Secretary of State

Office of Professional Regulation

SOCIAL WORKER

Disclosure Document for Clinical Social Workers

First Name	Middle Initial	Last Name
Willard		Metcalfe
		License # 089.0134851
Previous Name(s) (Maiden)		

Formal Education	Name of Institution:	Springfield College – Mass
	Dates Attended:	09/07/2007 - 5/1/2010
	Degree(s) awarded, if any:	Master of Social Work
Formal Education	Name of Institution:	College of St. Joseph
	Dates Attended:	09/01/1989 - 5/01/1993
	Degree(s) awarded, if any:	Bachelor of Science
Experience	Description of Practice:	Special Education Ele Education
	Location: City/State/Zip	Rutland, Vt
	Duration:	___/___/___ - ___/___/___
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	(YES) NO
	How often?	Weekly
Experience	Description of Practice:	West Central Behavioral Health Crisis Director
	Location: City/State/Zip	Claremont, NH
	Duration:	4/16/2016 - 4/01/2026
	Status:	Full-Time ✓ Part-Time
	Receive supervision or peer consultation?	(YES) NO
	How often?	Monthly
Experience	Description of Practice:	Health Care + Rehabilitation Director of Developmental Services
	Location: City/State/Zip	Spfld, Vt
	Duration:	5/01/2002 - 01/10/2016
	Status:	Full-Time Part-Time

	Receive supervision or peer consultation?	(YES) NO
	How often?	Weekly

Scope of Practice	**Therapeutic Orientation:**	
	Area of Specialization:	Crisis
	Treatment Methods:	DBT, CBT, Motivational Interviewing
	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 07/08/2026