

**A-5 – FACILITY STAFFING DATA - Page 1**

**INSTRUCTIONS:** Use this double sided form to identify all staff of the facility. Designate volunteers by placing a “V” after their names. Use additional sheets as needed.

Facility Name:			Provider #:		Counselor Information			(A minimum of 30% of all staff who provide counseling services shall be licensed or certified.)		
Employee Information:	Date Hired	Last TB Test Date	First Aid and CPR required for licensed facilities only.		Licensed? Yes/No/ N/A	Certified? Yes/No/N/A	Registered? Yes/No/N/A	Certified/Registered By:	Effective and expiration dates of: Licensure, Certification, or Registration	
			First Aid: Date of last Training	CPR: Date of last Training				<a href="#">Approved Certifying Organizations</a>		
								OR		
								* Licensed As:		
								A. Psychologist	D. LCSW	
								B. MFT	E. Registered Intern	
								C. Physician		
Name: _____								_____	_____	Effective date
Title: _____								_____	_____	Expiration date
Scheduled hours per week: _____								_____	_____	Expiration date
Name: _____								_____	_____	Effective date
Title: _____								_____	_____	Expiration date
Scheduled hours per week: _____								_____	_____	Expiration date
Name: _____								_____	_____	Effective date
Title: _____								_____	_____	Expiration date
Scheduled hours per week: _____								_____	_____	Expiration date
Name: _____								_____	_____	Effective date
Title: _____								_____	_____	Expiration date
Scheduled hours per week: _____								_____	_____	Expiration date
Name: _____								_____	_____	Effective date
Title: _____								_____	_____	Expiration date
Scheduled hours per week: _____								_____	_____	Expiration date

**\* LICENSED PROFESSIONALS AND INTERN QUALIFICATION REQUIREMENTS**

Licensed professional means a physician licensed by the Medical Board of California; a psychologist licensed by the Board of Psychology; or a clinical social worker or MFT licensed by the California Board of Behavioral Sciences, or an intern registered with the California Board of Behavioral Sciences or with the Board of Psychology.

**A-5 – FACILITY STAFFING DATA – Page 2**

Facility Name:			Provider #:		Counselor Information (A minimum of 30% of all staff who provide counseling services shall be licensed or certified.)				
Employee Information:	Date Hired	Last TB Test Date	First Aid and CPR required for licensed facilities only.		Licensed? Yes/No/N/A	Certified? Yes/No/N/A	Registered? Yes/No/N/A	Certified/Registered	Effective and expiration dates of: Licensure, Certification, or Registration
			First Aid: Date of last Training	CPR: Date of last Training				By: <a href="#">Approved Certifying Organizations</a> OR * Licensed As: A. Psychologist D. LCSW B. MFT E. Registered Intern C. Physician	
Name: _____ Title: _____ Scheduled hours per week: _____								_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
Name: _____ Title: _____ Scheduled hours per week: _____								_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
Name: _____ Title: _____ Scheduled hours per week: _____								_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
Name: _____ Title: _____ Scheduled hours per week: _____								_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
Name: _____ Title: _____ Scheduled hours per week: _____								_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date

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