

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: Approved Certifying Organizations	Effective and expiration dates of: Licensure, Certification, or Registration
			First Aid: Date of last Training	CPR: Date of last Training				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 _____
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*** 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.

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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: Approved Certifying Organizations 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
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