Email to
HS_BHRS_MISCredentialing@smcgov.org

Information must be completed by applicant agency

THIS FORM IS FOR TERMINATING STAFF ONLY

Effective Date: _____

Check all that applies: **Therapist Number:** ☐ **Avatar Account:** ☐ **VPN Account:** ☐
Outlook Account: ☐

NAME:

Last _____ **First** _____ **Middle** _____

Position: _____ **Applicant's Discipline:** _____

Gender ☐ **M** ☐ **F** **Work Phone:** _____-___

Contracted Provider Agency: _____ **(e.g., Caminar, Telecare, StarVista)**

Program Name/Worksite: _____ **Program Director/Supervisor:** _____

If you have questions about the information requested on this form please email HS_BHRS_MISCredentialing@smcgov.org

The information provided is correct and current on the date of my signature.

_____ _____
Print Name of Program Director/Supervisor Agency

_____ _____
Signature of Program Director/Supervisor Date