San Mateo County Behavioral Health & Recovery Services

BHRS AOD Contractor Avatar Termination Credentialing Form

APPLICANT & AGENCY INFORMATION

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., Pyramid, P90, OCG)**

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

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