



San Mateo County Behavioral Health & Recovery Services

## BHRS AOD Contractor Avatar Termination Credentialing Form APPLICANT & AGENCY INFORMATION

Email to [HS\\_BHRS\\_MISCredentialing@smcgov.org](mailto: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