



San Mateo County Behavioral Health & Recovery Services

**BHRS MH 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., Caminar, Telecare, StarVista)

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

If you have questions about the information requested on this form please email HS_BHRS_IT_Support@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