**CMHPSM SUD Provider Network Application & Re-Credentialing Application Attachment A: Staff Credentials**

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| **Provider Name:** |  | **Application Date:** |  | **Initial App:** **Renewal App:** | | | |
| **Please include as many copies of Attachment A as necessary to cover all applicable staff members indicate page number(s):** | | | | **Page #:** |  | **of:** |  |

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|  | **Staff** | | **Education**  (Can Leave blank if not required for service) | | **Clinical License Information** | | | | **MCBAP Certification / Development Plan** | **Other Information** | |
| **#** | **Last Name** | **First Name** | **Degree** | **Grad Date** | **License Type** | **License #** | **Exp Date:** | **Licensor:** | **NPI #:** | **Other** |
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