**CMHPSM SUD Provider Network Application & Re-Credentialing Application Attachment B: Background Check Verification**

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

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|  | **Staff Information** | | | **Most Recent Criminal Background Review** | | | **Motor Vehicle Record** | | **I-9 E-Verify** | |
|  | **Last Name** | **First Name** | **Position** | **Date** | **Data Source(s)** | **Outcome** | **Date** | **Outcome** | **Date** | **Outcome** |
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