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|  | **Tennessee Department of Children’s Services****Clinical Service Provider Qualifications** |

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| --- | --- |
| Today’s Date: |       |

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| --- | --- | --- | --- |
| Name of Staff Member: |       | Agency: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Hire Date: |       | Position Title: |       |

Is Staff Member Licensed in Tennessee?: [ ]  Yes [ ]  No

|  |  |  |  |
| --- | --- | --- | --- |
| If Yes, License Number: |       | Month/Year License Obtained: |       |

If Not Licensed, Please Complete the Following:

|  |  |  |  |
| --- | --- | --- | --- |
| Year Obtained Master’s Degree: |       | Field of Study: |       |

|  |  |
| --- | --- |
| Month/Year Began Supervision Hours Toward Licensure: |       |

|  |  |
| --- | --- |
| Type of Licensure Being Pursued: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Timeline for Completion (eg. 4 years, 6 years, etc): |       | Total Hours Required: |       |

|  |  |
| --- | --- |
| Name of Supervisor for Licensure Hours: |       |

|  |  |
| --- | --- |
| Supervisor’s TN License Number: |       |