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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: |  |

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

Is Staff Member Licensed in Tennessee?:  Yes  No

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

If Not Licensed, Please Complete the Following:

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| --- | --- | --- | --- |
| 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: |  |