CONFIRMATION OF CREDENTIALS FOR SUD CLINICAL STAFF

Report Submission: This form is to be completed and submitted annually upon request, prior to annual audit.

Program Name: _____

Completed By: _____

Date: _____

Employee Name	Position Title	Degree Title (ex: BSW, BA, MSW)	Michigan Professional License #	License Expiration Date	MCBAP Credential Title or Plan (ex: CADC, CCJP-R)	MCBAP Credential Expiration Date	Carenet Status: SATS, SATP or CCS	Name of Supervisor (Must hold CCS or CCS plan)

LAKESHORE REGIONAL ENTITY