ATTACHMENT: PARTICIPATING STAFF

To be completed by an official at the agency requesting participation in the Perinatal CBT Training and signed by the Executive Sponsor or Chief Executive Officer.

Provider Name: _____

Level of Care: _____

Program Name (if applicable): _____

Name	*Role (Clinician, Supervisor, Leadership, PE Point Person)*	*Credential/Licensed*	*Salaried or Contract*

Completed by (Name/Title): _____

Signature: _____ Date: _____

Exec. Director Signature: _____ Date: _____