# ATTACHMENT: PARTICIPATING STAFF

To be completed by an official at the agency requesting participation in the ESFT RFA 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* |
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Completed by (Name/Title): _____

Signature: _____ Date: _____

Exec. Director Signature: _____ Date: _____