

ATTACHMENT: PARTICIPATING STAFF

To be completed by an official at the agency requesting participation in the Prolonged Exposure (PE) Program and signed by the Executive Sponsor or Chief Executive Officer.

Provider Name: _____

Level of Care: _____

Program Name (if applicable): _____

<i>Name</i>	<i>Role (Clinician, Supervisor, Leadership, PE Point Person)</i>	<i>Credential/Licensed</i>	<i>Salaried or Contract</i>
_____	_____	_____	_____
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Completed by (Name/Title): _____

Signature: _____ Date: _____

Exec. Director Signature: _____ Date: _____