ATTACHMENT E: PARTICIPATING STAFF

To be completed by an official at the agency requesting participation in the DBT 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:** ____________