



Tennessee Department of Children's Services

Clinical Service Provider Qualifications

Today's Date: _____

Name of Staff Member: _____ Agency: _____

Hire Date: _____ Position Title: _____

Is Staff Member Licensed in Tennessee?: Yes No

If Yes, License Number: _____ Month/Year License Obtained: _____

If Not Licensed, Please Complete the Following:

Year Obtained Master's Degree: _____ Field of Study: _____

Month/Year Began Supervision Hours Toward Licensure: _____

Type of Licensure Being Pursued: _____

Timeline for Completion (eg. 4 years, 6 years, etc): _____ Total Hours Required: _____

Name of Supervisor for Licensure Hours: _____

Supervisor's TN License Number: _____