CPSP Practice/Clinic Name: ______________________ Date: ______________________

National Provider Identifier: ______________________

**PRACTITIONERS PROVIDING CPSP SERVICES (list all staff currently providing CPSP services including qualifications)**

| (A) PRACTITIONER NAME | (B) CPSP PRACTITIONER TYPE (MD/DO, CNM, NP, PA, LM, RN, LVN, SW, PSY, MFT, RD, HE, CCE, CPHW) | (C) PRACTITIONER QUALIFICATIONS | (D) SERVICE(S) PROVIDED* OB | B | CO | HE | N | PSY | CC | CON | P | (E) YRS OF EXP. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Select One | LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____ | | | | | | | | | | ____ |
| | Select One | LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____ | | | | | | | | | | ____ |
| | Select One | LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____ | | | | | | | | | | ____ |
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| | Select One | LIC/CERT/REG#: ____ SCHOOL: ____ DEGREE: ____ YEAR: ____ | | | | | | | | | | ____ |

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* OB = Obstetrics/Gynecology B = Backup Physician CO = Client Orientation
HE = Health Education N = Nutrition PSY = Psychosocial
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| Authorized agent name: | Signature: | Date: |
|---|---|---|

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