



**CLINICAL STAFFING INFORMATION FORM**

**Complete one form per applicable employee**

**FACILITY NAME:** \_\_\_\_\_

**Staff Name:** \_\_\_\_\_

**Position/Title:** \_\_\_\_\_

**Date (or anticipated) of hire:** \_\_\_\_\_



**EDUCATION**

**Specific degree(s) obtained:** \_\_\_\_\_

**Year:** \_\_\_\_\_

**Certification (if applicable):** \_\_\_\_\_

**CAC full certification # and expiration date:** \_\_\_\_\_

**YEARS OF EXPERIENCE**

Clinical	Drug/Alcohol Direct Services	Supervision

**Resume, Degree and Transcript Submitted**

I (the applicant) acknowledge that my signature is verification that I have completed this checklist truthfully and accurately, and I understand that my statements herein are made subject to the penalties of 18 Pa.C.S.§4904 (relating to unsworn falsification to authorities).

\_\_\_\_\_  
**APPLICANT PRINT NAME**

\_\_\_\_\_  
**APPLICANT SIGNATURE**

\_\_\_\_\_  
**DATE**