Pennsylvania
Department of Drug and Alcohol Programs

DDAP-EFM-5079
Rev. 08-2024

NURSING STAFFING FORM

Complete one form per applicable employee

FACILITY NAME: _____

Staff Name: _____

Position/Title: _____

Date (or anticipated) of hire: _____

EDUCATION

Specific degree(s) obtained: _____

Year: _____

License (if applicable): _____

DEA full certification # and expiration date (if applicable): _____

YEARS OF EXPERIENCE

Medical	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**

SUBMIT FORM