St. Clair County Community Mental Health

Level 1 Authorization Training Attestation

Please submit to your HR/Training Department when completed. **Note: Due prior to Privileging and Credentialing Renewal Date.**

Staff Name: _____

Program: _____

Date Completed:	Training Name:
	Admin. Procedure #01-002-0015 Clinical Services Protocols/Practice Guidelines
	Admin. Procedure #01-003-0011 Provider Enrollment & Credentialing
	Admin. Procedure #02-001-0015 Treatment Authorization
	Admin. Procedure #02-003-0011 Utilization Management
	Admin. Procedure #08-002-0010 Procedure Codes & Definitions
	Screening and Assessment Tools / Service Protocols / Treatment Protocols Please list each protocol reviewed that is applicable to your position and/or program below. • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____

Total Training Hours: *(total time to complete/review trainings)* _____

Staff Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____