**Prevention Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Month/ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Please Print)

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| **Staff Name** | **Position/Title**  **(indicate if Contracted)** | **Hire Date** | **End Date** | **MCBAP Certification**  **or indicate if Specifically Focused** | **Expiration Date** | **Supervisor Name/Credentials** |
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**Please complete all fields and email by the *5th of each month to*** [**tthisse@dwihn.o**](mailto:tthisse@dwihn.o)**rg**