St. Clair County Community Mental Health Authority

Level 1 Authorization Training Attestation

~ due prior to Privileging and Credentialing Renewal Date ~
(please submit to the Training Department)

Staff Name: _____

Program: _____

Date Completed:	Training Name:
	Clinical Service Protocols (please list each protocol reviewed – applicable to position/program). Clinical Protocols link below: http://198.109.89.71/policies/policy_files/Chapter01/01-002-0015%20Clinical%20Protocols%20and%20Practice%20Guidelines.pdf Screening and Assessment Tools: https://scccmh.org/screening-assessment-tools/ Service Protocols: https://scccmh.org/service-protocols/ Treatment Protocols: https://scccmh.org/treatment-protocols/ • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____
	Policy #01-003-0011 Provider Enrollment & Credentialing
	Policy #02-001-0015 Treatment Authorization
	Policy #02-003-0011 Utilization Management
	Policy #08-002-0010 Procedure Codes & Definitions

Total Training Hours *(total time to complete training)*: _____

Staff Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____