**CMHPSM Provider Network Application & Re-Credentialing Application Attachment D: Licensed Clinical Practitioner Background Check Verification**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Name:** |  | **Application Date:** |  | **Initial App:**  **Renewal App:** | | | |
| **Please include as many copies of Attachment D as necessary to cover all applicable staff members indicate page number(s):** | | | | **Page #:** |  | **of:** |  |

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|  | **Staff Information** | | **Initial Criminal Background (Prior to Hire)** | | **Most Recent Criminal Background Check** | | **Motor Vehicle Record Check** | | **E-Verify / I-9 Verification** | | **CMH Recipient Rights Background Check** | |
|  | **Last Name** | **First Name** | **Hire Date** | **Initial Check Date** | **Last Check Date** | **Clear / Not Clear** | **Date** | **Clear / Not Clear** | **Date** | **Clear / Not Clear** | **Date** | **Clear / Not Clear** |
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