

**PLEASE TYPE ALL REQUEST FORMS SUBMITTED TO THE
SYSTEM SUPPORT SERVICES
REQUEST FOR CLINICIAN STAFF NUMBERS**

MENTAL HEALTH

▶Provider/Corporate Name: _____		STAFF: _____ (For Info. Sys. Use Only)
▶Clinic Name: _____		
▶Provider Number: _____		
▶Provider Type: ☐ Mental Health		
▶Contact Person: _____		▶Phone #: _____
▶Staff Name: _____		▶Phone #: _____
<i>First</i>	<i>Middle</i>	<i>Last</i>
▶Sex: _____		
▶Ethnicity: (Circle One)		
A = White	F = Vietnamese	K = Other Asian
B = Black	G = Laotian	L = Other
C = Native American	H = Cambodian	M = Unknown
D = Latino	I = Japanese	N = Other Southeast Asian
E = Chinese	J = Filipino	
▶SS #: _____ - _____ - _____		▶Birthdate: _____
▶Start Date: _____		End Date: _____
▶License #: _____		▶Renewal Date: _____ ▶State: _____
▶Languages: (Check all that apply)		
_____ English	_____ Spanish	_____ Vietnamese
_____ Japanese	_____ Filipino Dialect	_____ Sign Language
_____ Laotian	_____ Cambodian	
_____ Other	_____ Chinese Dialect	
▶Staff Mask: (Check the applicable disciplines for this staff)		
_____ Educator	_____ Intern	_____ Medical Records
_____ MFC Counselor	_____ Nurse	_____ Occ. Therapist
_____ Pharmacist	_____ Physician	_____ Physician Assistant
_____ Psych Tech	_____ Psychiatrist	_____ Psychologist
_____ Rehab Counselor	_____ Social Worker	_____ Unlicensed Worker

(For Information Systems Use Only)		
Class _____	Field One _____	
Date of Request: _____	Date Completed: _____	Completed By: _____

SEND FORM TO: INFORMATION SYSTEMS

Attn: System Support
2000 Embarcadero Cove, 4th Floor
Oakland, CA 94606
Tel: (510) 567-8181 Fax: (510) 567-8161

▶ = MANDATORY FIELDS