SBHC Resume Submission Form

Submit this form to: DHSS_DPH_SBHC@delaware.gov

Personal Information:

Name: ____

Start Date: ______________

New Hire's E-mail address: ______________________________

Licensed Practitioner (if applicable): ___________________________

Title(s) at the center (check all that apply):

- ❒ Center Coordinator
- ❒ Administrative Assistant
- ❒ Physician
- ❒ Registered Dietician
- ❒ Certified Family Nurse Practitioner, (CFNPP)
- ❒ Certified Pediatric Nurse Practitioner, (CPNP)
- ❒ Physician Assistant, (PA-C)
- ❒ Licensed Clinical Social Worker, (LCSW)
- ❒ Licensed Professional Mental Health Counselor, (LPMHC)

Center Name: ____

(If the provider covers more than one site, a separate form must be completed for each site.)

Replacement Information:

Individual is replacing—

Name: ______________________________

Title: ______________________________

Verification:

The practitioner on this form possesses the appropriate license and/or certification, and their resume reflects training and/or experience in the service areas offered at the centers.

Select one:

- o Yes
- o No

Attachments:

- ❒ Resume
- ❒ Criminal Background Check

Submission Details:

Name of Individual Submitting form: ________________________

Submission Date: ______________