ACT TEAM COMPOSITION/QUALIFICATIONS CHECKLIST

PROVIDER: _____

POSITION	NAME	DOH	ED	**LIC/ CERT	EXP	**ACTT TRAINING	**ARI	**PCP THINKING	**PC PLANNING	CRC	**HCR	SUPER PLAN	SUPER	DATE QUALS MET
TEAM LEADER												NA	NA	
PSYCHIATRIST												NA	NA	
RN												NA	NA	
RN												NA	NA	
OTHER MH PROF												NA	NA	
OTHER MH PROF												NA	NA	
OTHER MH PROF												NA	NA	
OTHER MH PROF (VR)												NA	NA	
SA SPECIALIST												NA	NA	
CPSS														
ADM ASSIST			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
ADD CLINICAL:														

** INCLUDE DATE