Sacramento County

Department of Health Services

Division of Behavioral Health Services

OTHER QUALIFIED PROVIDER STUDENT APPLICATION

Agency: _____ **Date:** _____.

Contact Person: _____ **Phone:** _____.

I attest that I, _____, am a student at an accredited college or university participating in a field placement at this agency. I understand that I may provide services as an Other Qualified Provider, throughout this placement.

Name of College/University _____.

☐ Medical Student Clinical Clerkship. I understand that all of my documentation must be co-signed by a psychiatrist.

☐ Doctoral Level Student. I understand that all of my documentation must be co-signed by a licensed PHD or MD.

My internship begins on _____ and ends on _____
Date Date

Clinical Supervisor's Name: _____ Discipline _____ License#: _____
Print Name

Student: _____ _____
Signature Date

Clinical Supervisor: _____ _____
Signature Date

_____ Date:_____
Approval: BHS Quality Management

7001-A East Parkway, Suite 300 • Sacramento, California 95823 • phone (916) 875-0844 • fax (916) 875-0877 •