

Ohio Department of Job and Family Services
**CREDENTIALS FOR PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES
 AND MEMORANDUM OF UNDERSTANDING**

Child's Name <i>(first and last)</i>	Date of Birth
Specify the therapy being provided to the child	
Professional Experience (please describe your professional experience with the therapy being provided to the child)	
Education and Training (please list all specific education and training relative to the therapy being provided to the child)	
Professional Credentials	
Name of Provider <i>(first and last)</i>	
Name of Practice/Office	
Street Address of Practice/Office	
City, State and Zip Code	(Area Code) Telephone Number
Ohio License #	Licensing Board
<p><i>My therapeutic interventions will comply with all treatment aspects contained in Ohio Administrative Code rules 5122-26-16 "Special treatment and safety measure," 5122-26-16.1 "Mechanical restraint and seclusion," 5122-26-16.2 "Physical restraint" and 5122-26-16.3 "Aversive behavioral interventions and plans." I proclaim competence to the therapeutic technique(s) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.</i></p>	
Signature of Provider	Date