



YOLO COUNTY

# Health & Human Services Agency

Resource · Partner · Support System

## Attestation For Oversight of Non-Licensed Staff Providing SMH & SUD Services

1. I, \_\_\_\_\_, attest that all Specialty Mental Health and/or Substance Use Disorder Services provided by me will fall within my scope of practice and will be provided under the direction of \_\_\_\_\_.

\_\_\_\_\_  
Non-Licensed Staff Signature

\_\_\_\_\_  
Credential

\_\_\_\_\_  
Date

2. I, \_\_\_\_\_, attest that I meet the minimum qualifications described by the applicable licensing board to supervise \_\_\_\_\_ and that all Specialty Mental Health and Substance Use Disorder Services provided by \_\_\_\_\_ will be provided under my direction.

\_\_\_\_\_  
LMHP/LPHA Signature

\_\_\_\_\_  
Credential

\_\_\_\_\_  
Date