



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
Andrew Jackson Building, 5th Floor
500 Deaderick Street
NASHVILLE, TENNESSEE 37243

CERTIFIED FAMILY SUPPORT SPECIALIST
INACTIVE STATUS REQUEST

A Certified Family Support Specialist whose certification is in good standing and is in good standing with his or her employer and is unable to meet the requirements of certification due to an unforeseen circumstance, may request inactive status.

Inactive status will not be granted for failure to comply with the On-Going Education Guidelines of certification or reported violations of the Certified Family Support Specialist Code of Ethics.

- Do not alter the form from its original format.
- Write legibly in only black or blue ink.
- Do not use nicknames or abbreviated forms of your legal name.

1) Name (*please print*): _____

Certification Number: _____ Certification Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (____) ____ - _____ Email: _____

1) Are you currently employed by an agency that is a TDMHSAS-licensed or otherwise approved agency, and under the direct supervision of a mental health professional?

Yes

No

If yes, please provide the following employment information:

Employer: _____

City: _____ State: _____ ZIP: _____

Supervisor's Name: _____

Telephone Number: (____) _____ - _____

3) Please briefly describe the extenuating circumstance(s) that renders you unable to meet the required competencies and/or scope of activities requirements of certification:

My signature below affirms that all of the information contained in this verification form is true and correct to the best of my knowledge. I understand while on inactive status, I will not present myself as a Certified Family Support Specialist, and nor will I engage in or perform any activity for which a Family Support Specialist certification is required.

I understand that knowingly providing false information shall be grounds to terminate my certification.

Signature of Applicant

Date

Do Not Write Below This Line

Internal TDMHSAS – OCY Use Only

Date received: _____

Date reviewed: _____ Approved _____ Not-approved _____

Date letter of findings mailed to applicant: _____

If approved, date inactive status letter was mailed to agency: _____

Date information was recorded in data-base: _____

Notes: _____

Processed by: _____