



STATE OF TENNESSEE  
 DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES  
 OFFICE OF CHILDREN AND YOUTH  
 Andrew Jackson Building, 5<sup>th</sup> Floor  
 500 Deaderick Street  
 NASHVILLE, TENNESSEE 37243

## TENNESSEE CERTIFIED FAMILY SUPPORT SPECIALIST CERTIFICATION RENEWAL APPLICATION

**Please Print**

### Renewal Application PART I – Applicant Contact Information and Verification of Status

Full Name \_\_\_\_\_

Certification Number: \_\_\_\_\_ Certification Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

- |  | Circle: |    |
|--|---------|----|
|  | Yes     | No |
| • I have successfully completed 15 hours of recognized continuing education.   | Yes     | No |
| • I certify that I have not committed any violations to the TCFSS Code of Ethics; in addition, I have no reports of violation to the TCFSS Code of Ethics. | Yes     | No |

If you circled "No" on any of the statements above, please explain: \_\_\_\_\_

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## **Renewal Application PART II – Verification of Ongoing Education**

Fifteen (15) hours of ongoing education are required annually to maintain active certification and must be earned within the annual certification period. Please refer to Section IX of the TCFSS Handbook for ongoing education requirements.

List the title and date of the training, the sponsoring organization, and the number of hours for each training attended. Submit this application with a copy of the Certificate of Attendance or Completion for each training listed.

- |    |                          |               |
|----|--------------------------|---------------|
| 1) | _____                    | _____         |
|    | Title of the Training    | Sponsor       |
|    | _____                    | _____         |
|    | Number of Training Hours | Training Date |
| 2) | _____                    | _____         |
|    | Title of the Training    | Sponsor       |
|    | _____                    | _____         |
|    | Number of Training Hours | Training Date |
| 3) | _____                    | _____         |
|    | Title of the Training    | Sponsor       |
|    | _____                    | _____         |
|    | Number of Training Hours | Training Date |
| 4) | _____                    | _____         |
|    | Title of the Training    | Sponsor       |
|    | _____                    | _____         |
|    | Number of Training Hours | Training Date |

**Total Number of Hours** \_\_\_\_\_

**My signature below affirms that all of the information attached to and contained in this certification renewal application is true and correct to the best of my knowledge. I understand that knowingly providing false information shall be grounds for termination of certification.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Note:** The Certification Renewal Application and all required documentation must be submitted at least 45 calendar days prior to the end of the current certification period.

Currently working as a TCFSS  
If no, omit part III of the application.

Yes

No

**Renewal Application PART III – Employment Summary** – Completed by the supervising mental health professional and faxed to the Office of Statewide Systems of Care, attention Melissa McGee, at 615-253-6822. May be omitted if not currently working as a TCFSS.

A Tennessee Certified Family Support Specialist (TCFSS) who is employed must be under the general supervision of a mental health professional in accordance with acceptable guidelines and standards of practice as defined by the State. Provide the following information regarding the agency staff that provides direct supervision:

Supervisor's Name: \_\_\_\_\_

Credentials: \_\_\_\_\_ Position: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

Email: \_\_\_\_\_

TCFSS's Name: \_\_\_\_\_

TCFSS's job title within the agency: \_\_\_\_\_

Full-time / part-time (circle one)      Number of hours worked per week: \_\_\_\_\_

Certification number: \_\_\_\_\_ Certification Date: \_\_\_\_\_

- |   | Circle: |    |
|---|---------|----|
| • The applicant is employed by this agency.   | Yes     | No |
| • The applicant is under my general supervision.  | Yes     | No |
| • The applicant performs duties specified in the TCFSS Scope of Activities.             | Yes     | No |
| • The applicant has successfully completed 15 hours of recognized continuing education. | Yes     | No |

If you circled "No" on any of the statements above, please explain: \_\_\_\_\_

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**I verify that all of the information contained in this document is true and correct to the best of my knowledge and that the above-named applicant is employed by this agency.**

\_\_\_\_\_  
Signature of Supervising Mental Health Professional

\_\_\_\_\_  
Date

**Do Not Write Below This Line**

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**Internal TDMHSAS OSSOC Use Only**

Date received: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Approved \_\_\_\_\_ Not-approved \_\_\_\_\_

Date letter of findings mailed to applicant: \_\_\_\_\_

Date information recorded in database: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Processed by: \_\_\_\_\_