COASTLINE Therapy Group LLC

INFANT-TODDLER PROGRAM PROVIDER ROSTER

Name of ITP Provider Agency

I certify that this is a complete roster of official signatures of all employees or subcontractors of my agency who are or will be providing services under the Infant-Toddler Program. If I employ new staff, I will submit to the CDSA the additional signatures and licensure information within the month of their employment. I will attach a copy of current license or certification and signed Confidentiality statement for each staff member. If the staff person is a provider of special instruction (CBRS) services and is not Infant-Toddler Family Specialist certified, I will attach a copy of the person's ITP Supervision Plan.

Printed Name of CEO or Owner of ITP Provider Agency

Signature

Date of Signature

Employee Name	Job Title	Indicate Licensure or Certification and Expiration Date	Assigned Counties
1. [Printed Name] [Legal Signature]	[Printed]	[Licensure or Certification] [Expiration Date]	
2. [Printed Name] [Legal Signature]	[Printed]	[Licensure or Certification] [Expiration Date]	
3. [Printed Name] [Legal Signature]	[Printed]	[Licensure or Certification] [Expiration Date]	
4. [Printed Name] [Legal Signature]	[Printed]	[Licensure or Certification] [Expiration Date]	
5. [Printed Name] [Legal Signature]	[Printed]	[Licensure or Certification] [Expiration Date]	
6. [Printed Name] [Legal Signature]	[Printed]	[Licensure or Certification] [Expiration Date]	