SUPR GAMBLING DISORDER PROFESSIONAL STAFF FORM

Those organizations delivering gambling disorder services as specified in Section 7 under Service Requirements B are required to register qualified staff. Please complete this form and send to the SUPR Help Desk at doit.suprhelp@illinois.gov.

Organization Name: _____

SUPR Provider Number: _____

Staff Name: _____ Position: _____

Last 4 Digits of Social Security No.*:_____ Email Address: _____

Telephone Number: (____)_____

Professional License(s) or Certification(s)
(list type and number of each)

Type:	**Number:**	**Expiration Date:**
LPC ☐ LCPC ☐	_____	_____
LSW ☐ LCSW ☐	_____	_____
CADC ☐	_____	_____
PCGCs ☐	_____	_____
Other: _____	_____	_____

Date completed 30-hour gambling training: _____

1. Have you been convicted of a felony or had any subsequent incarceration within the past two years preceding employment at this facility? ☐ Yes ☐ No

   If yes, a request for exception to hire, prior to employment, must be submitted to the Department.

2. As applicable, has a background check been conducted in the Child Abuse and Neglect Tracking System (CANTS) for any staff who will be providing services as specified in 2060.313(d)? ☐ Yes ☐ No

My signature confirms that the information on this document is correct and I have the credentials and training specific to gambling disorder counseling.

_____ _____
Staff Signature Date

_____ _____
Authorized Organization Representative Signature Date

** **This form will be stored in a secure location and information will not be redisclosed.** An individual's social security number is solicited for the purpose of verifying his or her identity and related personal information required under these regulations. The disclosure of an individual's social security number is voluntary and its solicitation by the department is authorized by Illinois Revised Statutes, 20 ILCS 301.*