



STATE OF TENNESSEE  
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES  
OFFICE OF CONSUMER AFFAIRS  
CORDELL HULL BUILDING, THIRD FLOOR  
425 FIFTH AVENUE, NORTH  
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:

- 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: \_\_\_\_\_

---

---

---

---

---

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

Twenty (15) hours of continuing education are required annually to maintain active certification and must be earned within the annual certification period. Please refer to Section VI of the TCPS Handbook for Continuing 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 sent to the Office of Consumer Affairs at 1-615-253-3920. 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 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
  - I certify that I have not committed any violations to the TCFSS Code of Ethics; in addition I have had no reports of violation to the TCFSS Code of Ethics.      Yes  
    No
  -

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

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

---

---

**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**

---

**Internal TDMH OCA Use Only**

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

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

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

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

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

---

---

---

---

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