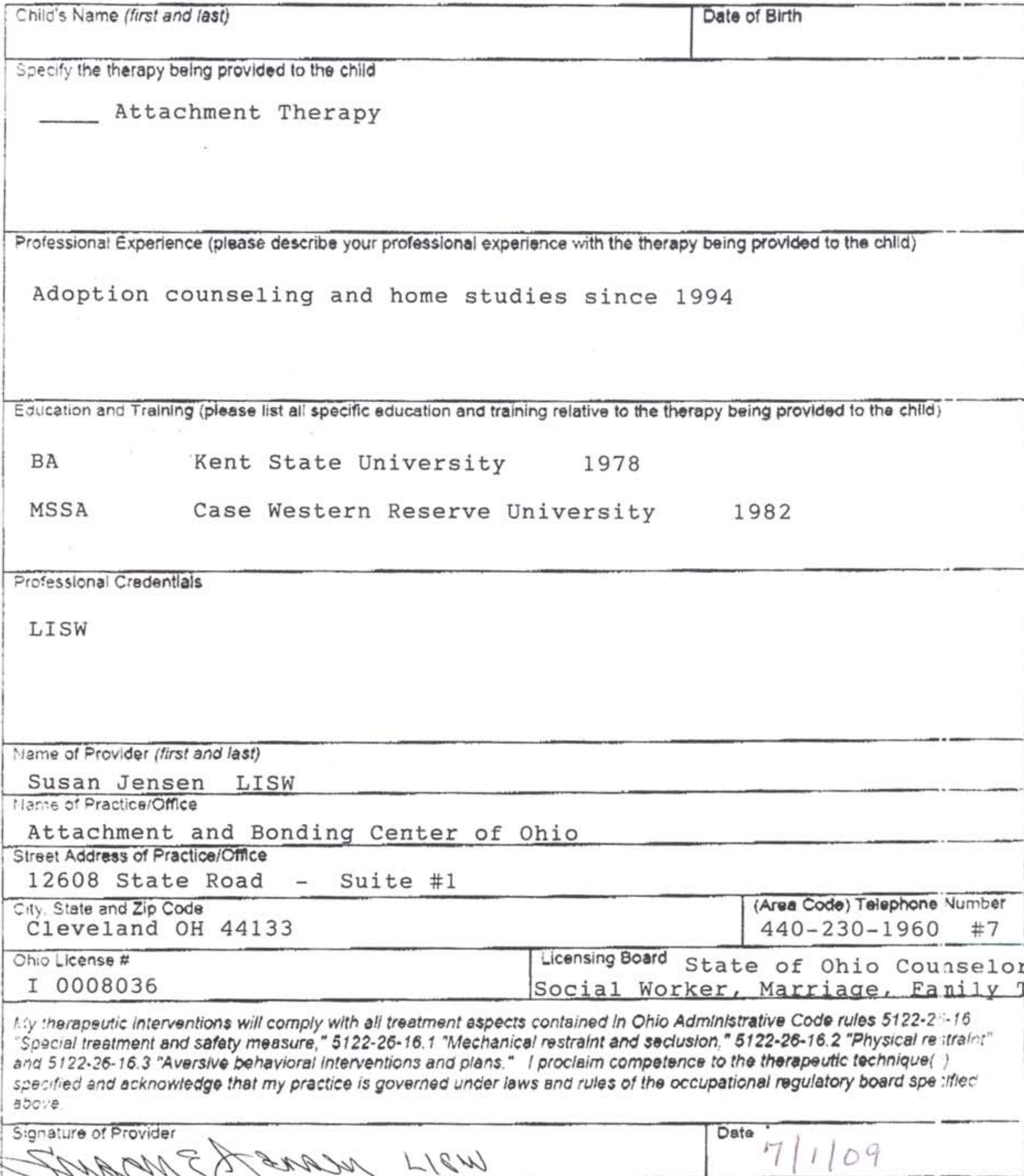
Ohio Department of Job and Family Services

CREDENTIALS FOR PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES AND MEMORANDUM OF UNDERSTANDING



Child's Name *(first and last)*	Date of Birth

Specify the therapy being provided to the child

____ Attachment Therapy

Professional Experience (please describe your professional experience with the therapy being provided to the child)

Adoption counseling and home studies since 1994

Education and Training (please list all specific education and training relative to the therapy being provided to the child)

BA Kent State University 1978

MSSA Case Western Reserve University 1982

Professional Credentials

LISW

Name of Provider *(first and last)*
Susan Jensen LISW

Name of Practice/Office
Attachment and Bonding Center of Ohio

Street Address of Practice/Office
12608 State Road - Suite #1

City, State and Zip Code	(Area Code) Telephone Number
Cleveland OH 44133	440-230-1960 #7

Ohio License #	Licensing Board
I 0008036	State of Ohio Counselor Social Worker, Marriage, Family Thera

My therapeutic interventions will comply with all treatment aspects contained in Ohio Administrative Code rules 5122-26-16 "Special treatment and safety measure," 5122-26-16.1 "Mechanical restraint and seclusion," 5122-26-16.2 "Physical restraint" and 5122-26-16.3 "Aversive behavioral interventions and plans." I proclaim competence to the therapeutic technique( ) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.

Signature of Provider	Date
Susan E Jensen LISW	7/1/09

JFS 01052 (Rev. 4/2009)