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 Assessment

Attachment Therapy

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

I have utilized attachment therapy with my clients since January 2000.

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

Since 2000, I have attended yearly trainings given by ATTACh that focus on Reactive Attachment Disorder and attachment therapy.

Professional Credentials

MSW	1997
EMDI	1999
LISW	2000
NASW	2000
ATTACh	2000
LISW-S	2008

Name of Provider *(first and last)*

Linda Orick, LISW-S

Name of Practice/Office

Attachment and Bonding Center of Ohio

Street Address of Practice/Office

3966 Brown Park Drive - Suite H

City, State and Zip Code	(Area Code) Telephone Number
Columbus OH 43026	614-850-9800 #2

Ohio License #	Licensing Board
I8786	Ohio Counselor and Social Worker Board

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(s) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.

Signature of Provider	Date
Linda Orick, LISW-S	7/1/09

JFS 01052 (Rev. 4/2009)