SANTA CLARA COUNTY
Behavioral Health Services

TERMINATION FORM

Today's Date:

Agency Name:

Submitter Name:

Provider Information

Effective date of when provider leaves/left agency:

First Name and Last Name:

NPI#:

myAvatar ID:

Reason for leaving: Select One

Send completed form to BHSDCredentialing@vhp.sccgov.org and BHSDBusinessOffice@hhs.sccgov.org