

RENEWAL APPLICATION FOR CERTIFICATION

CBSCC

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- J. As they are part of the application, the pre-Site Survey, supporting policies, procedures and other documents specific to Chapter 23, need to be electronically submitted to Brenda Pitts at bpitts@odmhsas.org. **Hard copies or faxed copies of these items will not be accepted.**
- K. I hereby assure that the applicant organization operates without discrimination as to race, color, gender, age, degree of disability, handicapping condition, veteran status, religion, or ethnic origin.
- L. I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.
- M. As an authorized representative of the applicant organization, I verify this application and attached documents are true and correct.
- N. ***I acknowledge that my agency's certification review will be conducted under the ODMHSAS Standards and Criteria in effect at the time of the review.***

Failure to submit all documentation required for this application can result in expiration of certification.

(Date)

(Signature of Program Director)

(Printed Name of Program Director)

(Date)

(Clinical Director)

(Credentials)

(Printed Name of Clinical Director)