

Oklahoma Department of Mental Health  
and Substance Abuse Services

**INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATIONS -  
EATING DISORDER TREATMENT PROGRAMS**

A. \_\_\_\_\_  
(Legal Name of Organization) (Director)

B. \_\_\_\_\_  
(Administrative/Mailing Address)

C. \_\_\_\_\_  
(Physical Address)

Directions to facility: \_\_\_\_\_

D. Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

E. Target Population:  
 Females  Adolescents  
 Males  Adults

F. I have enclosed the following:

1. A non-refundable fee (check or money order) payable to the Oklahoma Department of Mental Health and Substance Abuse Services in the amount of \$300.00
2. Copies of the following required information:
  - (a) Current and approved fire inspection from the state or local Fire Marshal or local fire department for each site/satellite location
  - (b) Organizational Chart with names and positions delineated
  - (c) List of Board Members, including addresses and phone numbers, and Certificate of Incorporation
  - (d) Program Description

G.  I hereby assure that the requesting agency operates without discrimination as to race, color, gender, religion, age, degree of disability, handicapping condition, veteran status, or ethnic origin.

H.  As an authorized representative of the applicant organization, I verify this application and attached documents are true and correct.

I.  I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.

J.  ***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.***

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Program Director)

\_\_\_\_\_  
(Printed Name of Program Director)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Clinical Director or Licensed Staff)

\_\_\_\_\_  
(Credentials)

\_\_\_\_\_  
(Printed Name of Clinical Director Or Licensed Staff)