

**APPLICATION FOR CERTIFICATION
EATING DISORDER TREATMENT PROGRAMS
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K. *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)

(revised 9/15/2015 – CL)