

**RENEWAL APPLICATION FOR CERTIFICATION
OPIOID SUBSTITUTION TREATMENT**

Page 2 of 2

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

- 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.*

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

(Date)

(Signature of Program Director or Sponsor)

(Printed Name of Program Director or Sponsor)

(Date)

(Clinical Director)

(Credentials)

(Printed Name of Clinical Director)

(revised 9/15/2015 – CL)