



**INITIAL APPLICATION  
OPIOID SUBSTITUTION TREATMENT  
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- G.  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.
- H.  As an authorized representative of the applicant organization, I verify this application and attached documents are true and correct.
- I.  ***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 Sponsor)

\_\_\_\_\_  
**(Printed Name of Program Sponsor)**

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

\_\_\_\_\_  
(Signature of Medical Director)

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

\_\_\_\_\_  
**(Printed Name of Medical Director)**