COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

NOTICE OF CHANGES FOR LPS DESIGNATED FACILITY AUTHORIZED PROFESSIONAL STAFF

Date _____

Name of Facility _____ Contact Person _____

Phone Number _____ FAX # _____

Please complete all that apply.

The following professional staff person(s) are no longer LPS authorized at this facility:

NAME	DATE OF REVOCATION	VOL REVOKED	INVOL REVOKED	REASON
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

*You may attach additional information if needed.

Updated licensure information is as follows:

NAME	DISCIPLINE	LICENSE NUMBER and/or NEW EXPIRATION DATE

Name Changes:

NAME/INFORMATION IN FILES	CORRECTED NAME/INFORMATION

Please FAX (213) 365-2481 within <u>1 week</u> of changes