(TADF 10-11-99)

LAC-DMH EMERGENCY SERVICES BUREAU

PMRT PROGRAM

FAX fully completed appl to 213-365-2481

APPLICATION FOR APPROVAL FOR DESIGNATION

(ATTENDING STAFF OF DESIGNATED FACILITIES)

DESIG FACILITY -

APPL LAST NAME -

APPL FIRST NAME -

APPL CATEGORY

- ☐ I Resident
- ☐ II Att Staff with Admit Priv
- ☐ III Att Staff without Admit Priv

LAST 4 DIGITS OF SSN 0

CREDENTIAL

- ☐ DO
- ☐ LCSW
- ☐ LPT
- ☐ MD
- ☐ MFT
- ☐ PhD
- ☐ RN
- ☐ Unlic Resident

STATE LIC NUMB 0

PROCTORING OR PROBATIONARY PERIOD

- ☐ Completed
- ☐ Not applicable
- ☐ Not completed

If not completed, explain on separate sheet

EXPIRATION DATE

NUMBER OF YRS OF MENTAL HEALTH EXPERIENCE 0

HAS APPLICANT EVER LOST ATENDING STAFF PRIVILEGES?

- ☐ No
- ☐ Yes

If yes, explain on separate sheet

MINIMUM LENGTH OF TIME ON ATENDING STAFF OF REQUESTING FACILITY

- ☐ 90 Days (Minimum for Category II)
- ☐ Six Months (Mimimum for Category III)
- ☐ Other If other, explain on separate sheet

TRAINING OR TESTING DATE REQUESTED

REASON FOR DESIGNATION REQUEST:

Certificate of Applicant: I attest that all statements made in this application are true and complete to the best of my knowledge. I understand that any false statements or omissions of material facts will subject me to disqualification or relinquishment of designation.

Date _____ Signature of Applicant _____ Print Name -

Certificate of the Professional Person Clinically in Charge of the Designated Facility as defined by the California Code of Regulations, Title 9, and Section 822.

" I attest that this applicant:

- *** is a member in good standing of the Attending Staff as defined by the California Code of Regulations, Title 9, Section 823 of this facility,**
- *** has the required clinical training,**
- *** is currently professionally licensed by the State of California,**
- *** meets all pertinent requirements of state law and regulation as well as the requirements of the Los Angeles County L.P.S. Designation Standards,**
- *** will receive active peer review and/or clinical supervision consistent with membership on the attending staff to ensure that these services are provided with the highest clinical and ethical standards, and**
- *** if non-medical staff, will have access to appropriate psychiatric consultation whenever exercising this authority."**

Date _____ Signature of Prof Person Clinically in Charge of the Designated Facility _____ Print Name -

(Dept use only)

Exam Score 0

Scheduled Re-test Date _____ ☐ Not Applic

Date _____ Medical Director- Designee Signature _____