Behavioral Health Provider Certification and Transmittal Request

Select License Subclass:

Facility License Number: _____ Facility Capacity/Occupancy: _____

Facility Physical Address: _____

City: _____ AZ Zip Code: _____

>Does the licensee currently have a 'Certification and Transmittal'?

If yes, certification effective date: _____

>Is the health care institution requesting certification under Title XIX of the Social Security Act?

If yes, requested effective date: _____

>Is the health care institution accredited?

If yes, name of the accrediting organization: _____

Accreditation period: _____ to _____

_____ _____

Print name of requestor Signature of requestor

To be completed by ADHS staff:

Licensure Period: _____ To: _____

Accreditation Period: _____ To: _____

Select one:

○ *Re-certification*

○ *New certification*