Request for Variance from Requirements for Certification of Preadmission Screening Clinicians

*[If this variance is a request to certify an individual as a Certified Preadmission Screening Clinician the **APPLICATION FOR CERTIFICATION AS A CERTIFIED PREADMISSION SCREENING CLINICIAN** or if it is a request to recertify the **Application for Recertification as a Certified Preadmission Screening Clinician** must be submitted at the same time]*

Name of CSB:

Name of individual for whom a variance is requested:

Original Request: ◯ **Extension Request:** ◯ **Recertification Request:** ◯

Initial or Extension Requirements :

Educational requirements: ☐

Orientation requirements: ☐

Supervisory qualifications: ☐

Grandfathering requirements: ☐

Recertification Requirements:

Continuing education requirements: ☐

Requirements to receive supervision: ☐

Requirements to complete preadmission screenings and Emergency Services/crisis intervention work during certification cycle: ☐

Other [specify]:

Explain concisely what variance you are requesting and the requested duration of the variance: (100 words or less Please do not exceed the word count requested. You will be contacted if additional information is needed)

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Explain what actions will be taken to eliminate the need for this variance (200 words or less Please do not exceed the word count requested. If additional information is needed you will be contacted)

Signature of Executive Director: **Date:**

Contact Person Name (should there be any questions by DBHDS):

Email: **Phone:**

Office Use Only:

Variance Denied: Date:

Signature

Variance Approved: Date:

Signature

Variance expires or a renewal request must be approved by this date:

[Variance will expire in one year or less]