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|  | DEPARTMENT OF SOCIAL AND HEALTH SERVICES  DOMESTIC VIOLENCE INTERVENTION TREATMENT (DVIT) PROGRAM  **Add, Change, or Remove Direct Service Staff  for a Certified DVIT Program** | | | | | | |
| All forms must be signed and filled out completely. Incomplete forms will not be accepted. See Washington Administrative Code (WAC) 388-60B for Domestic Violence Intervention Treatment (DVIT) Program standards. There is no fee to submit this application.  **Submit the completed application, and supporting documents to:**  Department of Social and Health Services (DSHS)  Domestic Violence Intervention Treatment Program Certification  PO Box 45470  Olympia, WA 98504-5470 | | | | | | | |
| **Program Information** | | | | | | | |
| PROGRAM NAME | | | | | | | TELEPHONE NUMBER (WITH AREA CODE) |
| PHYSICAL ADDRESS CITY STATE ZIP CODE | | | | | | | |
| DIRECTOR’S NAME | | | TELEPHONE NUMBER (WITH AREA CODE) | | | | EMAIL ADDRESS |
| **New or Changing Direct Treatment Staff** | | | | | | | |
| NAME | | STAFF LEVEL REQUESTED (TRAINEE, STAFF OR SUPERVISOR) | | | | DSHS FORM 10-210, BACKGROUND CHECK AND DOH CREDENTIAL ATTACHED. | |
|  | |  | | | | **Yes** | |
|  | |  | | | | **Yes** | |
| **Removing Direct Treatment Staff** | | | | | | | |
| NAME | | | | | | LAST DATE OF SERVICE | |
|  | | | | | |  | |
|  | | | | | |  | |
| **Required Documentation for New or Changing Direct Treatment Staff** | | | | | | | |
| A statement of qualifications (DSHS form #10-210); and  A current DOH license as a licensed or registered counselor and the results of current criminal history background checks, conducted in each state the person has lived in for the last ten years. | | | | | | | |
| **Attestation** | | | | | | | |
| I certify under penalty of perjury that the information provided in this application for certification is true and correct. I understand that any material misrepresentation or misstatement of fact may result in sanctions, including the denial or loss of program certification. | | | | | | | |
| DIRECTOR’S SIGNATURE DATE | | | | | PRINT DIRECTOR’S NAME | | |
| **For Department of Social and Health Services Use Only** | | | | | | | |
| APPROVED BY: | | | | Certified from:  to: | | | |
| DSHS STAFF SIGNATURE DATE | | | | | PRINT STAFF NAME | | |