Application Type: New Renewal Preferred Training Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Employee ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Discipline & License #: AMFT LMFT ACSW LCSW APCC LPCC MD DO   
  
 RN Psy.D Ph.D Tribal Ranger Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Work Site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Number:

**License/Registration#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Email Address:

*To be authorized as:*

RUHS BH Employee Employee of RUHS BH contract provider

Employee at RUHS BH designated facility

Other professional (i.e., emergency department doctor, nurse, social worker, tribal ranger)

**REQUIRED: The undersigned certifies that the applicant has \_\_ \_\_\_\_\_years of experience** providing services to individuals with mental illness. In addition, the applicant meets the necessary requirements for designation according to RUHS BH Policy #142.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Applicant Job Title Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*REQUIRED\*\* Signature of Supervisor Job Title Date**

Name of Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Supervisor’s Work Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Email of Supervisor:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Send this completed form to LPS 5150 Certification & Oversight at: 5150@ruhealth.org**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**The section below to be completed by LPS 5150 Staff regarding authorization outcome.**

**RENEWAL:** Based upon the LPS 5150 Certification and Oversight review of the applicants 5150s written, the applicant is hereby granted a renewal of 5150 authority to initiate detention, upon probable cause, of mentally disordered persons in a facility designated by Riverside County as a facility for 72‑hour treatment and evaluation in accordance with the above policies and the Welfare & Institutions Code. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**NEW AUTHORIZATION**: Based upon the completion of the training on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and passing the 5150 exam, the applicant is hereby granted 5150 authority to initiate detention, upon probable cause, of mentally disordered persons in a facility designated by Riverside County as a facility for 72‑hour treatment and evaluation in accordance with the above policies and the Welfare & Institutions Code. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**DENIED**: Applicant's request for 5150 authorization is denied for the following reason(s):

Did not pass 5150 exam. Date of exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Score:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
 Renewal denied. Upon LPS 5150 review, applicant has excessive deficiencies in 5150s written.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(LPS 5150 Staff Signature) (Date)