State of Nevada
Division of Public and Behavioral Health
727 Fairview Dr, Suite E
Carson City, NV 89701
Phone (775) 684-1030 Fax (775) 684-1073

EXISTING PROVIDER OF TREATMENT APPLICATION

(For submission with a New Initial Domestic Violence Program Application)

(*Only to be used by Providers of Treatment that have been approved by the Division of Public and Behavioral Health or the Commission on Domestic Violence as a Provider of Treatment* ***AND*** *that are currently employed, or retained as an independent contractor, in the position of a Provider of Treatment by a currently certified Nevada Program for the Treatment of Domestic Violence*)

PROVIDER INFORMATION

Name of Provider: _____

Address: _____
Street/P.O. Box City State Zip

Telephone: _____ Fax: _____

Email Address: _____

PROOF OF APPROVAL AS A PROVIDER OF TREATMENT (check one box)

☐ Submit proof of approval as a provider of treatment issued by the Division of Public and Behavioral Health or the Committee on Domestic Violence (such as approval of your original provider of treatment application);

OR

☐ I do not have written approval (in this case the Division will verify if you are on the approved list of providers)*

*If proof of prior approval of a provider of treatment cannot be verified you may be required to submit a regular Provider of Treatment Application.

CONTINUING EDUCATION REQUIREMENT

Upload proof of having satisfactorily completed at least 15 hours of approved domestic violence training during the 2 years immediately preceding the date on which you were hired by the program.

PROVIDER CURRENT EMPLOYMENT INFORMATION **(only need to list one)**

Name of NV certified domestic violence program: _____

Certificate Number: _____

Agency Address: _____
Street/P.O. Box City State Zip

**Employment information will be verified with your current employer

SUPERVISOR OF TREATMENT INFORMATION

Name of supervisor of treatment overseeing your work: _____

INITIAL DOMESTIC VIOLENCE PROGRAM INFORMATION

Name of New Initial Domestic Violence Program (name on program application being submitted) which this application will be included with: _____

- I attest I have never been convicted of a crime which demonstrates unfitness to act as a supervisor of treatment.
- I attest that I am free of violence.
- I attest I am not currently an abuser of prescription drugs, alcohol, or a use of illegal drugs.

I hereby declare, under penalty of perjury, that all information provided and attached to this application is to the best of my knowledge true, accurate, and complete and I have not withheld, misrepresented, or falsely stated any information relevant to this application.

Provider's Signature: _____ Date: _____