

<p style="text-align: center;">DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT</p> <p style="text-align: center;"><b>Application for Approval as Accreditation Body Under 42 CFR § 8.3(b)</b></p>	<p>Form Approved: OMB Number 0930-0206 Expiration Date: 03/31/2013 See OMB Statement on Reverse</p> <hr/> <p><b>DATE OF SUBMISSION</b></p>		
<p><b>Note:</b> This form is required by 42 CFR § 8.3(b) pursuant to Sec. 303, Controlled Substances Act (21 USC 823) and the Drug Abuse Prevention and Control Act of 1970 (42 USC 275 (a)). Failure to report may result in the suspension or revocation of the accreditation body approval.</p>			
<p><b>1. NAME OF ACCREDITATION BODY</b></p>	<p><b>2. PURPOSE OF APPLICATION</b></p> <p>New <input type="checkbox"/>      Renewal <input type="checkbox"/></p>		
<p><b>3. ADDRESS OF ACCREDITATION BODY</b> <i>(Include ZIP Code)</i></p>	<p><b>4. TELEPHONE NUMBER</b> <i>(Include Area Code)</i></p> <p><b>5. FAX NUMBER</b> <i>(Include Area Code)</i></p> <p><b>6. E-MAIL ADDRESS</b></p>		
<p><b>7. NAME AND ADDRESS OF RESPONSIBLE OFFICIAL</b> <i>(Include ZIP Code)</i></p>	<p><b>8. TELEPHONE NUMBER</b> <i>(Include Area Code)</i></p> <p><b>9. FAX NUMBER</b> <i>(Include Area Code)</i></p> <p><b>10. E-MAIL ADDRESS</b></p>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>11. Application</b> Center for Substance Abuse Treatment Division of Pharmacologic Therapies Substance Abuse and Mental Health Services Administration Attention: OTP Certification Program 1 Choke Cherry Road, Suite 2-1086 Rockville, MD 20857</p> <p>Overnight: 1 Choke Cherry Road, Suite 2-1086 Rockville, MD 20850</p> <p>Dear Sir/Madam</p> <p>As the official responsible for the accreditation body, I submit this application in triplicate for approval to serve as an accreditation body under 42 CFR Part 8.</p> <p>A. I have a copy of, or access to 42 CFR Part 8, Certification of Opioid Treatment Programs, including 42 CFR § 8.4, Accreditation Body Responsibilities. I have read, understand and will comply with these regulations which address the accreditation of opioid treatment programs (OTPs) that treat narcotic addiction with approved opioid drugs.</p> <p>B. I have a copy of, or access to 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. I have read and understand the requirements to maintain the confidentiality of alcohol and drug abuse treatment patient records. I agree to protect the identity of all patients in accordance with the regulations and agree to maintain records of accreditation activities for 5 years from the creation of the record.</p> <p>C. Attached is evidence of the accreditation body's nonprofit status (i.e., of fulfilling Internal Revenue Service requirements as a nonprofit organization) if the accreditation body is not a State governmental entity or political subdivision.</p> <p>D. Attached is a set of accreditation elements and a detailed discussion showing how the proposed accreditation elements will ensure that each OTP surveyed by the accreditation body is qualified to meet or is meeting each of the Federal opioid treatment standards set forth under 42 CFR § 8.12.</p> </td> <td style="width: 50%; vertical-align: top;"> <p>E. 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<p><b>RESPONSIBLE OFFICIAL</b> <i>(Signature)</i></p>	<p><b>DATE</b></p>		

*Please send three copies of this form and all attachments to:*

Center for Substance Abuse Treatment  
Division of Pharmacologic Therapies  
Substance Abuse and Mental Health Services Administration  
Attention: OTP Certification Program  
1 Choke Cherry Road, Suite 2-1086  
Rockville, MD 20857

Overnight:  
1 Choke Cherry Road, Suite 2-1086  
Rockville, MD 20850

***The preferred method for submitting this form to CSAT/DPT is online at the DPT Web site, <http://dpt.samhsa.gov>. The Web site contains complete instructions for preparing and submitting your request. If you are unable to submit online, the form may be e-mailed as an attachment to [otp@samhsa.hhs.gov](mailto:otp@samhsa.hhs.gov) or sent by traditional mail (include three copies of all attachments) to the mailing address above.***

#### **Paperwork Reduction Act Statement**

Public reporting burden for this collection of information is estimated to average 2 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0206); Suite 7-1043, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0206.