CLINICAL SITE VERIFICATION

PROGRAM: _____

PROGRAM TYPE(S): _____

PROGRAM CODE(S): _____

_____

DATE SUBMITTED: _____ **BY:** _____

DATED NEEDED BY (PLEASE GIVE 4 WEEKS): _____

FACILITY #	**FACILITY NAME**	**LOCATION**	**CLEARANCE** *(OSDH use ONLY)*

*Training facility to complete facility #, name and location.
Email to Stacey.marrazo@health.ok.gov.
If unavailable, send to lindseyj@health.ok.gov or NAR@health.ok.gov .