State Facility Unit
Department of Health Service
Licensing and Certification
Program Flexibility Request Form

Facility:_____

Address:_____

_____ Zip: _____

Administrator:_____ Date: _____

Compliance Coordinator:_____

Program Flexibility is requested for CCR, Title 22, Section(s):_____

_____
Please list all levels of care that you are requesting program flexibility.

Proposed alternate concepts, methods, policies and procedures, techniques, equipment, personnel qualifications:

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