Washington State Department of Health

Suicide Prevention Training Program Application Packet

Contents:

1. 971-018 ..... Contents List and Mailing Information ..... 1 page
2. 971-019 ..... Application Instructions ..... 2 pages
3. 971-020 ..... Suicide Prevention Training Program Application ..... 3 pages
4. RCW/WAC and Online Website Links ..... 1 page

In order to process your request:

Mail your application and other documents to:

Suicide Prevention Training Program
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Washington State Department of Health

Application Instructions Checklist

All information should be printed clearly in blue or black ink. It is your responsibility to submit the correct required forms. You will be notified in writing of any outstanding documentation needed to complete the process.

Use the following checklist to help guide you through the application.

☐ **Check One:**
Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **1. Demographic Information:**
Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/ Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Phone, Fax and Cell Numbers: Enter the owner's phone, cell, and fax numbers.

Email and Web Address: Enter the owner's email and facility Web addresses, if applicable.

Facility/Agency Name: Enter the facility's name as advertised on signs, brochures, or Web site.

Physical Address: Enter the facility's physical street location including city, state, zip code, and county.

Phone, Fax and Cell Numbers: Enter the facility's phone, cell, and fax numbers.

Mailing Address: Enter the facility's mailing address, if different than the physical address.

☐ **2. Contact Information:**
List the name, title, phone number and email address of the person that can be contacted about your application.

☐ **3. Program Information:**
Provide the requested information about the program offered.

☐ **4. Program Representative Attestation:**
The authorized program representative must sign and date this application.

Additional Requirements:

All programs must provide the following documents with your application:

- A syllabus for your training program.
- A description of the method of selecting future instructors.
- A list of class objectives for your training program.
- A description of the evaluation methods for the course and the instructors.
- An outline of the curriculum plan showing all subjects and the length in hours of each subject is taught.
- Policies and procedures for maintaining training and testing records.
- List of instructors and their qualifications
  Instructors must have demonstrated knowledge and documentation of their experience related to suicide prevention and:
  - An active license to practice as a health care professional;
  - A bachelor's degree or higher in public health, social science, education or a related field from an accredited college or university; or
  - At least three years of experience delivering training in suicide prevention.
- Access to online courses, if necessary

Note: To enhance our research and data compilation, we will ask approved programs to track results.

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Suicide Prevention Training Program Application

Check One:

- ☐ Association
- ☐ Corporation
- ☐ Federal Government Agency
- ☐ Limited Liability Company
- ☐ Limited Liability Partnership
- ☐ Limited Partnership
- ☐ Municipality (City)
- ☐ Municipality (County)
- ☐ Non-Profit Corporation
- ☐ Partnership
- ☐ Sole Proprietor
- ☐ State Government Agency
- ☐ Tribal Government Agency
- ☐ Trust

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
Legal Owner/Operator Entity Name	
Mailing Address	

City	State	Zip Code	County
Name of School or Program			
Physical Address			
City	State	Zip Code	County
Mailing Address (if different from Physical)			
City	State	Zip Code	County

Phone (enter 10 digit #)	Fax (enter 10 digit #)
Web Address	

2. Contact Information

Contact Name	Title
Phone Number	Email Address

3. Training Program Information:

Provide the following information about the program offered.

Course Title	Number of Sessions

Length of Program	Cost of Course
☐ Three Hours ☐ Six Hours ☐ Other: _____	

Attendees	Select the delivery method for your training program
☐ Open Enrollment ☐ Employees Only	☐ In-Person ☐ Electronic ☐ Electronic and In-Person

Type of Application

☐ New Application ☐ Reapproval

Target Professions (all or specify)

☐ Behavioral Health Professions ☐ Chiropractors ☐ Nurses ☐ Physicians/Physician Assistants
☐ Occupational Therapists ☐ Pharmacists ☐ Physical Therapists/Physical Therapist Assistants
☐ Naturopaths ☐ Dentists ☐ Dental Hygienists
☐ Athletic Trainers ☐ Optometrists ☐ Acupuncturists and Eastern Medicine Practitioners
☐ Veterinarians/Veterinary Technicians ☐ Osteopathic Physicians/Osteopathic Physician Assistants
☐ All Professions

Specialized Content:

☐ Aging Community ☐ Chemical Dependency ☐ Imminent Harm
☐ Veterans ☐ Youth/Students ☐ Advanced Standards ☐ None

4. Program Representation Attestation:

Name of Authorized Representative	Title

Signature of Authorized Representative	Date (mm/dd/yyyy)

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Suicide Assessment, Treatment, and Management Training, RCW 43.70.442

Minimum Standards for Suicide Prevention Training Programs for Healthcare Professionals, WAC 246-12-601 through 246-12-650