



**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
LANTERMAN-PETRIS-SHORT (LPS) ACT
INITIAL AND RENEWAL AUTHORIZATION APPLICATION**

(Please Print or Type)

TO BE COMPLETED BY CANDIDATE'S SUPERVISOR (Failure to complete all items may result in the application not being processed.)

Training ID		Date of requested training (initial only)			
<input type="checkbox"/> Initial Application <input type="checkbox"/> Renewal Application		Work Location Change From:		Training or testing date previously completed (if applicable)	
County Employee Number (non-county employees supply the last four digits of the SSN)					
Candidate's Name			Job Title		
<input type="checkbox"/> Resident		<input type="checkbox"/> Professional Staff with Admitting Privileges		<input type="checkbox"/> Professional Staff without Admitting Privileges	
<input type="checkbox"/> County/DMH or Contracted Facility Staff					
Name of Agency, Program, or Hospital					
Work Address			City	Zip Code	
Work Telephone		Fax	E-mail		
Number of years experience as a licensed MH professional			List all other current facilities at which LPS Authorized (if applicable)		
Start Date with LACDMH or Contracted Agency:			Required: Completed initial 6 month probationary period with LACDMH or Contracted Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Current job description of candidate which requires that he/she be authorized (please check one):					
<u>On-Site</u>			<u>Mobile</u>		
<input type="checkbox"/> County Clinic/County Contracted Clinic Employee			<input type="checkbox"/> Hospital Employee		
<input type="checkbox"/> LPS Designated Facility (inpatient) Employee			<input type="checkbox"/> County Clinic/County Contracted Clinic Employee		
<input type="checkbox"/> LPS Designated Facility (inpatient) MD					
<u>Field Based Services</u>					
<input type="checkbox"/> FSP Specify:		<input type="checkbox"/> FCCS Specify:		<input type="checkbox"/> Other, Specify:	
Credential	<input type="checkbox"/> LPT	<input type="checkbox"/> LMFT	<input type="checkbox"/> LCSW	<input type="checkbox"/> RN	<input type="checkbox"/> NP
	<input type="checkbox"/> PhD/PsyD	<input type="checkbox"/> MD/DO	<input type="checkbox"/> Unlicensed Resident	<input type="checkbox"/> LVN (clinics only)	
	<input type="checkbox"/> Other, Specify:				
License No.				License Expiration Date	
I attest that all statements made in the application are true and correct.					
Applicant			Professional clinically in charge of Designated Facility or Agency <i>(If applicant is clinically in charge then immediate supervisor must sign.)</i>		
Signature _____			Print Name _____		
Date _____			Signature _____ Date _____		
Office Use Only: This section to be completed after training and examination.					
Test Score:	Pass:	Fail:	Test Date:	Designation Expiration:	
DMH Regional Medical Director (Signature):					Date:
<p>RETURN <u>INITIAL</u> LPS TRAINING APPLICATION to: County of Los Angeles - Department of Mental Health Workforce Education and Training (W.E.T.) Division 695 S. Vermont Avenue, 15th Floor, Los Angeles, CA 90005 Phone No. (213) 251-6854 Fax No. (213) 252-8776 / 8775</p> <p>Note: The initial LPS Training Application should be submitted at least one month prior to selected scheduled training date.</p>					
<p>EMAIL <u>RENEWAL APPLICATION & NOTICE OF CHANGES</u> for Hospital/Facility Staff, Directly Operated and Contracted Staff, or Questions to: LPSCoordinator@dmh.lacounty.gov</p>					
Submit this form as an application for LPS training, renewal authorization and change of work location. Form must be completed for each facility at which individual desires authorization. The application will be forwarded to the Medical Director's Office for final LPS authorization, once training has been completed and test score added.					

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ATTESTATION FOR LPS AUTHORIZED APPLICANTS**

Certificate of Applicant:

I attest that all statements made in this application are true and correct. I acknowledge that any false or incomplete statement given here or an omission of material fact will result in my disqualification. I further acknowledge that I have reviewed the [LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Fifth Edition \(revised December 2010\)](#), and that I have read and understood this document, and will uphold all applicable legal, ethical, regulatory and reporting principles contained therein and in the standards of my professional license(s). Further, I will uphold basic ethical standards essential to the fulfillment of my responsibilities carried out in the application of my authority for involuntary detention, including but not limited to the following:

- Avoidance of circumstances where work based action may affect or appear to affect private financial interest or personal gain, financial or non-financial.
- Avoidance of any participation in a personal arrangement or business transaction which would generate potential or perceived conflict of interest or compromise my ability to provide treatment fairly and objectively.
- Avoidance of any circumstances that would hinder my ability to provide or refer to service that is of highest quality and effectiveness.
- Recognition and avoidance of any personal situation, habits or behaviors that might impair ability to provide competent care.
- Respect and protection of client confidential information, in accordance with applicable legal and regulatory standards.
- Performance of all duties in a manner that demonstrates an understanding of each client's personal dignity.
- Demonstration of highest standards of personal integrity in all work related activities carried out in the application of my authority for involuntary detention.

I acknowledge that, if I am given authority for involuntary detention, my failure to comply with the above principles and all laws, policies, by-laws or regulations related to involuntary detention, or with those portions of the [LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Fifth Edition \(revised December 2010\)](#) related to individuals (including any revisions thereafter adopted), will result in withdrawal of my involuntary detention authority. I acknowledge that involuntary detention authority may also be withdrawn without cause at any time by the LACDMH Director.

<hr/> Signature of Applicant	<hr/> Print Name	<hr/> Date	
<hr/> Credential, License No.	<hr/> Expiration Date		
<hr/> Designated Facility or Directly Operated Program or Contract Site Approved to Initiate LPS Involuntary Holds			
<hr/> Address	<hr/> City	<hr/> State	<hr/> Zip Code
<hr/> Work Telephone	<hr/> Email Address		
<hr/> Professional Clinically in Charge of Designated Facility or Approved Site (Print Name)	<hr/> Signature		