County of Orange, Health Care Agency (HCA), Behavioral Health Services (BHS)
Quality Management Services (QMS)

County of Orange

Contract Program's Attestation to the completion of the 2026 Annual Provider Training (APT)

By signing this attestation, you affirm that all clinical staff, the individuals who supervise them, and any additional staff designated as appropriate to complete the **2026 BHS ANNUAL PROVIDER TRAINING** have fully completed the required training. You further attest that the information provided is accurate to the best of your knowledge and reflects compliance with all applicable organizational training requirements.

I hereby attest that _____ provider number _____
(Program Name) (Provider #)

has fully completed the 2026 BHS Annual Provider Training for all required staff and supervisors on

_____
(Date)

Program Name

Business Phone Number Business E-Mail

Print Name (First and Last) Working Title

Signature Date

Please submit via secure email to:

BHPSUDSupport@ochca.com (for DMC-ODS)

SMHSClinicalRecords@ochca.com (for SMHS)

(Revised 08/2026)