Oklahoma State Department of Health
Protective Health Services, Medical Facilities
123 Robert S. Kerr, Suite 1702, Oklahoma City, OK 73102-6406
p. (405)426-8620 | planreview@health.ok.gov

Exception & Temporary Waiver Request

Note: (1) A separate exception and/or temporary waiver request form must be submitted for each regulation or FGI Guidelines requirement for which it is requested; (2) the fee of $500 is applicable per request; (3) all information pertaining to this request must be contained in this form to allow the waiver determination to be made without the need to refer to other plan review documentation and (4) exceptions are considered permanent or until that area effected is remodeled or changed, temporary waivers are granted for a limited time frame that expires on the date that is agreed upon between the facility and OSDH Plan Review.

The $500 fee per request must be mailed, along with a copy of this completed form, to:

Oklahoma State Department of Health
Financial Management – Receipting Unit
PO Box 268823
Oklahoma City, OK 73126-8823

☐**Temporary Waiver Request** **Time Frame of Temporary Waiver From ___/___/___ to ___/___/___**
☐**Exception Request**
☐**New Project** **If existing project, OSDH Project#: ____________**

Facility's Licensed Name or Proposed Name:	Address, including city and zip code
If Hospital Satellite, Name:	Address, including city and zip code
Hospital Department Request is Applicable to:	Building/Floor Location

I hereby request the OSDH Plan Review Department waive compliance with the regulation or requirement:

1.A: Regulation/FGI Guidelines Number: ____

1.B: Relevant text of regulation/FGI Guidelines requirement:

2. Describe what is proposed in lieu of compliance with the requirement:

3. **Provider's detailed explanation of how meeting the requirement would cause undue hardship: (Indicate exception cost implications associated with compliance or potential patient care improvements associated with the exception.)**

4. **Provider's detailed explanation of how approval of the exception or temporary waiver: (A) Will not limit the Capacity to provide adequate care; and (B) Does not jeopardize/affect patient or resident health and safety:**

5. **A floor plan or plan detail in 8 ½ x 11 format is attached to this form to show what is proposed in lieu of Compliance with the requirement and mailed to the address listed in the top right hand corner of this form.**

FACILITY AUTHORIZED REPRESENTATIVE	**FACILITY CLINICAL REPRESENTATIVE**
NAME:	NAME:
TITLE:	TITLE:
MAILING ADDRESS:	TELEPHONE:
EMAIL ADDRESS:	EMAIL ADDRESS:
SIGNATURE/DATE:	SIGNATURE/DATE:

ACHITECTURAL FIRM/DESIGN PROFESSIONAL

NAME:
TITLE:
MAILING ADDRESS:
EMAIL ADDRESS:
SIGNATURE/DATE:

For OSDH Use Only: The waiver/exception identified above is approved, approved with conditions, or denied as indicated below:

Reviewed/Approved by:________________________________ Date:___/___/___

☐Approved ☐Approved with Conditions ☐Denied

Approval Conditions or Reasons for Denial: