

## POLICY STATUS CHANGE FORM

\* Required

\* This form will record your name, please fill your name.

1. Date \*

2. Name of Requestor \*

3. Policy Number \*

4. Policy Name \*

\*\*\*

5. Change Action (Select all that apply) \*

- Delete
- Temporarily Suspend
- Administrative/Clinical Classification
- Policy Manager Transfer
- Division/Unit/Program Transfer

6. If change in Policy Manager, transfer from and to whom? \*

7. If change in Division/Unit/Program, transfer from and transfer to? \*

8. Date approved by Policy Committee \*

9. Reason for Change \*

- No longer required due to changes in best practices
- Changes in regulations, statutes, or program parameters, render policy unnecessary.
- Other (Explain)

10. If Other was selected, please Explain: \*