



Chemical Dependency Professional Trainee (CDPT) Certification Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Chemical Dependency Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation. This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the correct forms required.

Do you hold a credential in Washington State? Check yes or no. If you do hold a credential in Washington State, please provide your license number.

Application Fee. This fee is non-refundable. Check the online [fee page](#) for most current fees.

Select if the following applies:
Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information:
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

3. Other License, Certification, or Registration:

List all states, including Washington, where licenses are or were held. Check method of credential by: exam, endorsement, or grandfathered. Enter year issued and credential number. Attach additional completed pages if you need more space.

4. Declaration of Education and Experience:

Declare that you are obtaining the education and experience required to receive a CDP credential.

5. AIDS Education and Training Attestation:

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in [WAC 246-12-270](#). If AIDS education was included in your professional education or training, an additional course is not required.

6. Applicant’s Attestation:

You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse’s or registered domestic partner’s military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state’s declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Credentialing Requirements

Chemical Dependency Professional Trainee (CDPT)

Means an individual working toward the education and experience requirements for certification as a chemical dependency professional, and who has been credentialed as a CDPT.

All of the experience must be under an approved supervisor as defined in [WAC 246-811-049](#).

A CDPT can provide chemical dependency assessment, counseling, and case management to patients consistent with their education, training, and experience as documented by the approved supervisor.

- The first fifty hours of any face-to-face patient contact must be under direct observation of an approved supervisor or a chemical dependency professional.
- An approved supervisor or designated certified chemical dependency professional must be on-site and provide direct supervision when a CDPT is providing clinical services to patients until the approved supervisor documents in employee file that the CDPT has obtained the necessary education, training, and experience.

Renewal

Credential is renewed each year to correspond with the issuance date.

- CDPT must submit a signed declaration with their annual renewal that states they are enrolled in an approved education program, or have completed the educational requirements, and are obtaining the experience requirements for a CDP credential.

A CDPT certificate can only be renewed four times.

Continuing Education

Not required.

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Date
Stamp
Here

Revenue: 0207061000

Chemical Dependency Professional Trainee Certification Application

Do you hold a credential in Washington State? No Yes If yes, credential #

Select if the following applies: Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female				
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">Name</td> <td style="width: 25%; border: none;">First</td> <td style="width: 25%; border: none;">Middle</td> <td style="width: 25%; border: none;">Last</td> </tr> </table>			Name	First	Middle	Last
Name	First	Middle	Last			
Birth date (mm/dd/yyyy)	Place of birth					
	City	State				
Address						
City	State	Zip Code				
Country						
Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)				
Email address						
Mailing address if different from above address of record						
City	State	Zip Code				
Country						
Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.						
Have you ever been known under any other name(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s):						
Will documents be received in another name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s):						

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
 - b. Diverted controlled substances or legend drugs?
 - c. Violated any drug law?
 - d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Other License, Certification, or Registration

State/ Jurisdiction	License/Certification/Registration Type	Method Licensed			License/Certification/Registration	
		Exam	Endorse	Grandfathered	Year issued	Number

4. Declaration of Education and Experience

I declare I am obtaining the education and experience required to receive a chemical dependency professional credential.

Applicant's Initials	Date
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5. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that if I provide any false information, my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

- School curriculum
- Employer/Other

Applicant's Initials	Date
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6. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington State Department of

Health

Chemical Dependency Credentialing

P.O. Box 47877

Olympia, WA 98504-7877

360-236-4700

Registration / Certification / License Out of State Verification

Applicant Name: _____ Birth date: _____

I, _____, Secretary of _____,
hereby certify that _____

was granted state: Registration Certificate License

Number: _____ to practice _____

in the State of _____ on the _____ day of _____, 20_____.

On the basis of: Successfully passing the required examination. Grandfathered

Did the applicant take and pass the NAADAC exam? Yes No Score _____ Date _____.

Did the applicant take and pass the ICRC level II or higher exam? Yes No Score _____ Date _____.

Required Education? _____

Required Experience? _____

Status of License: Current Expiration Date: _____ Expired Date _____

Legal/Disciplinary Action: Yes No If Yes, explain: _____



Acting In Behalf of the:

Official Name Board _____

Phone _____

Secretary _____

Date Certification Prepared _____

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Washington State Department of
Health

Chemical Dependency Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Chemical Dependency Professional Supervision and Experience

Note: Use one form per supervisor for each time frame worked.

Print Clearly:

Applicant			
Name: Last	First	Middle	Birth date (mm/dd/yyyy)
Address:			
City:	State:	Zip Code:	
Phone (enter 10 digit #)	Business phone (enter 10 digit #)		
Direct Supervisor			
The above applicant requires verification of supervised experience for certification as a chemical dependency professional. Please complete the following.			
Supervisor Name: Last	First	Middle	Credential #
Street Address		Phone (enter 10 digit #)	
City	State	Zip Code	
Supervised Experience (WAC 246-811-045)			
From (mm/dd/yyyy):		To (mm/dd/yyyy):	
Competencies gained during the experience (WAC 246-811-047). The first fifty hours of any face-to-face client contact must be under the direct observation of an approved supervisor (WAC 246-811-049).			
I attest that the first fifty hours of face-to-face client contact was under my direct observation or I assigned a chemical dependency professional to have direct observation in my stead.			
Signature of Supervisor		Date	
Direct Supervisor			# of Hours
Face-to-face clinical evaluation (100 hours required)			
Other clinical evaluation (100 hours required)			
Face-to face counseling to include: Individual counseling, group counseling, and counseling family, couples, and significant others (600 hours required)			
Discussions of professional and ethical responsibilities (50 hours required)			
Transdisciplinary foundations: Understanding addiction treatment knowledge, application to practice, professional readiness, referral, service coordination, client, family, and community education. Documentation to include screening, intake assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client related data.			
AA degree = 1,650 hours required in transdisciplinary foundations BA degree = 1,150 hours required in transdisciplinary foundations MA degree = 650 hours required in transdisciplinary foundations Advanced Registered Nurse Practitioners, Licensed Counselors and Psychologists = 150 hours required in transdisciplinary foundations			
Total Number of Supervised Experience Hours			

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RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Chemical Dependency Professional Laws, RCW 18.205](#)

[Chemical Dependency Professional Rules, WAC 246-811](#)

OnLine

[AIDS Training Resources, Reference Page](#)

[Chemical Dependency Professional Program, Web Page](#)

ListServ

To receive emails regarding important chemical dependency Professional Information, please join our interested parties list at: [Listserv](#)