Washington State Department of Health

Chemical Dependency Professional Trainee Expired Certification Activation 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, contact the Customer Service Center at 360-236-4700 for more information. 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
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Chemical Dependency Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application Instructions Checklist

You will be notified in writing if further documentation is required.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay** Late Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired Certification Reissuance Fee.
  All fees are non-refundable. You can check the fee page for current fees.
- ☐ **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 certification. 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. Other License, Certification, or Registration.** List in date order, most recent to later, **all** credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional pages, if you need more space.
- ☐ **3. Professional Experience.** In date order, list all your professional work experience since your Washington State credential expired. Attach additional pages, if you need more space.
- ☐ **4. Education.** You must be enrolled in an approved educational program, or have completed the educational requirements, and are obtaining the experience requirements to be a chemical dependency professional.
- ☐ **5. AIDS Education and Training Attestation.** Required by **WAC 246-12-040**. If AIDS education was included in your professional education or training, an additional course is not required.
- ☐ **6. Disciplinary Action Attestation.** Required by **WAC 246-12-040**.
- ☐ **7. Applicant's Attestation.** You must sign and date this for us to process the application.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0207060000

Chemical Dependency Professional Trainee Expired Certification Activation Application

Please print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

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)	☐ Male ☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	**Place of birth**		
	City	State	Country

Address			
City	State	Zip Code	County
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	County
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)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Other License, Certification, or Registration (Include Previous Credentials in Washington State)

List **all** credentials you have held since last being certified in Washington State. List in date order, most current first. Include your last active certification in Washington State.

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently in force	
		Type	Number	Yr Issued		No	Yes

3. Professional Experience

In date order, list all your professional work experience since your Washington State credential expired.

Type of experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

4. Education and Experience

You must verify one of the following as required by **WAC 246-811-035**.

I certify that I am enrolled in an approved education program.

Applicant's Initials	Date

I certify that I have completed the educational requirements, and I am obtaining the experience requirements to obtain a chemical dependency professional credential.

Applicant's Initials	Date

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 should 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.

Applicant's Initials	Date

6. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials	Date

7. 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
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification Form

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: _____

_____

_____

_____

I further certify that the preliminary and professional education of this applicant was verified by this board prior to the examination of the applicant.

Seal

Acting In Behalf of the:

Official Name Board _____

Phone _____

Secretary _____

Date Certification Prepared _____

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Washington State Department of Health

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Chemical Dependency Professional Laws, RCW 18.205

Chemical Dependency Professional Rules, WAC 246-811

Standard of Professional Conduct, WAC 246-16

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