Substance Use Disorder Professional Certification Application Packet

Contents:

1. 670-061 ......Contents List/SSN Information/Mailing Information..................... 1 page
2. 670-072 ......Application Instructions Checklist.................................................. 3 pages
3. 670-190 ......License Requirements................................................................. 2 pages
4. 670-060 ......Substance Use Disorder Professional License Application..... 8 pages
5. 670-064 ......Verification of Supervision Experience and
   Statement of Qualifications ................................................................. 2 pages
6. RCW/WAC and Online Website Links.............................................................. 1 page

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your
application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW
26.23.150. It will be used under the state’s child support enforcement program to locate
individuals for purposes of establishing paternity and establishing, modifying, and
enforcing support obligations. You are not required to have or obtain a Social Security
Number to apply for or obtain a license from the Department of Health. If you do not
have a Social Security Number, you are still eligible to apply for and obtain a credential
if you meet the requirements. Please see the Declaration of No Social Security Number
Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

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:

Substance Use Disorder Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of
hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.
wa.gov.
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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 (FBI). 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.

☐ Application Fee. This fee is non-refundable. You can check the online fee page for current fees.

☐ Select if you are applying by:
   Traditional Training or Alternative Training

☐ 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. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. 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.

   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.

• If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

• Another jurisdiction means any other country, state, federal territory, or military authority.

3. Other License, Certification, or Registration:
List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

4. Education:
List in date order, most recent to later, your postsecondary education. Attach additional completed pages if you need more space.

5. Examination Data:
If you passed the National Association of Alcohol and Drug Abuse Counselors (NAADAC) or the International Certification Reciprocity Consortium (ICRC) exam, verification must be sent directly to this office by NAADAC or ICRC.

6. Course Topics Identification—Traditional Training Applicants:
At least 45 quarter or 30 semester credits must be in courses specific to alcohol and drug addicted individuals. Courses must address the topics listed in WAC 246-811-030(2), (a) through (w). List the course title and the course number. One course may be used for more than one topic area.

7. Course Topics Identification—Alternative Training Applicants:
At least 15 quarter or 10 semester credits must be in courses specific to alcohol and drug addicted individuals. Courses must address the topics listed in WAC 246-811-077(1) (a) through (g). List the course title and the course number. One course may be used for more than one topic area.
8. National Certification:
Applicants credentialed according to WAC 246-811-076 may submit a national certification listed in WAC 246-811-078 in place of educational requirements and supervision requirements. Proof of verification of your national certification must come directly from the certifying body.

9. Attestation of Recovery:
Effective July 28, 2019, ESHB 1768 requires all substance use disorder professional and substance use disorder professional trainee applicants to complete the attestation of recovery form.

10. 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.
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License Requirements

Traditional Training:
If you are an applicant applying by traditional training you must submit the following:

• Completed application and fee

Education:

• Provide official transcripts showing proof of completion of an associate’s degree or higher in human services or a related field from an approved school. Transcripts must be submitted directly from the college or school.

Or

• Provide official transcripts showing proof of successful completion of 90 quarter or 60 semester college credits in courses from an approved school.

Experience:
All experience required, must be under an approved supervisor. See WAC 246-811-049 for approved supervisor requirements.

The number of hours required is based off your level of formal education. See WAC 246-811-046.

• If you have an associate’s degree, provide proof of 2500 hours of Substance Use Disorder counseling.

• If you have a baccalaureate degree in human services or a related field, provide proof of 2000 hours of Substance Use Disorder counseling.

• If you have a master or doctoral degree in human services or a related field, provide proof of 1500 hours of Substance Use Disorder counseling.

Examination:
Provide proof of successful completion of the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination.

NAADAC Certification or ICRC International certification:
A person certified through NAADAC or the ICRC as an alcohol and drug counselor (ADC) or advanced alcohol and drug counselor (AADC), is considered to have met all of the experience requirements of WAC 246-811-046. Certification verifies the 45 quarter or 30 semester hours of topics listed in WAC 246-811-030(2)(a) through (w). Certification confirms your experience. Verification must be sent directly from NAADAC or ICRC.

You must still confirm the additional 45 quarter or 30 semester as described in WAC 246-811-030(1). Official transcripts are required.
Alternative Training
If you hold an active license in good standing of one of the following approved credentials, you may apply for certification by alternative training. See WAC 246-811-076.

- Advanced registered nurse practitioner
- Marriage and family therapist
- Mental health counselor
- Advanced social worker
- Independent clinical social worker
- Psychologist
- Osteopathic physician
- Osteopathic physician assistant
- Physician
- Physician assistant

Submit the following:
- Completed application and fee.

Education:
- Provide proof of successful completion of 15 quarter hours or 10 semester college credits in course work from an approved school. Proof of completion must be official transcripts submitted to the Department directly from the school. See WAC 246-811-077.

Experience:
All experience required, must be under an approved supervisor. See WAC 246-811-049 for approved supervisor requirements.
- If you hold an active license in good standing listed in WAC 246-811-076, provide proof of 1000 hours of Substance Use Disorder counseling.

Examination:
Provide proof of successful completion of the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination.

Examination:
All applicants must take and pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination.

National Certification:
Applicants credentialed according to WAC 246-811-076 may submit a national certification listed in WAC 246-811-078 in place of educational requirements and supervision requirements. Proof of verification of your national certification must come directly from the certifying body.
# Substance Use Disorder Professional Certification Application

Please print clearly. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

**Select One:**  
- Traditional Training  
- Alternative Training

**Select if the following applies:**  
- Spouse or Registered Domestic Partner of Military Personnel  
- Probationary License

## 1. Demographic Information

<table>
<thead>
<tr>
<th>Social Security Number (SSN)</th>
<th>National Provider Identifier Number (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If you do not have a SSN, see instructions)</td>
<td>(Enter 10 digit number)</td>
</tr>
</tbody>
</table>

- Male  
- Female  
- Prefer not to answer  
- X

**Name**  
- First  
- Middle  
- Last

**Birth date (mm/dd/yyyy)**

**Address**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

Country

<table>
<thead>
<tr>
<th>Phone (enter 10 digit #)</th>
<th>Fax (enter 10 digit #)</th>
<th>Cell (enter 10 digit #)</th>
</tr>
</thead>
</table>

**Email address**

**Mailing address if different from above address of record**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

**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. Personal Data Questions

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.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

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.)

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

List all states where credentials are or were held. Attach additional completed pages if you need more space.

<table>
<thead>
<tr>
<th>State</th>
<th>License/Certification/Registration Type</th>
<th>License/Certification/Registration</th>
<th>Method of Licensure</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Year Issued</td>
<td>Number</td>
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4. Education

List in date order all your post-secondary school(s) attended, major, month and year the degree was granted. Request your transcripts from the post-secondary school(s) you attended, and have the school send transcripts directly to the Department of Health.

<table>
<thead>
<tr>
<th>School</th>
<th>Degree</th>
<th>Major</th>
<th>Date degree granted</th>
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</table>
5. Examination Data  **WAC 246-811-060**

Select if you have taken and passed either of the following examinations:

- [ ] NAADAC, list the year __________  list the level __________
- [ ] ICRC, list the year _____________  list the level __________

Are you **nationally** certified by **NAADAC**?  [ ] Yes  [ ] No  List your certification type: ____________________

Are you **internationally** certified by **ICRC**?  [ ] Yes  [ ] No  List your certification type: ____________________

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6. Course Topics Identification—**WAC 246-811-030**

To be completed if you are applying by traditional training.

Minimum Requirements: An associates degree in human services or related field from an approved school, or successful completion of 90 quarter or 60 semester college credits in courses from an approved school. At least 45 quarter or 30 semester credits must be in courses specific to alcohol and drug addicted individuals and must include the topics listed below. Identify the course you took and the associated course number. One course may be used for more than one topic area.

<table>
<thead>
<tr>
<th>A. Understanding addiction.</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<th>B. Pharmacological actions of alcohol and other drugs.</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<th>C. Substance abuse and addiction treatment methods.</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<th>D. Understanding addiction placement, continuing care, and discharge criteria, including ASAM criteria.</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<th>E. Cultural diversity including people with disabilities and its implication for treatment.</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<th>F. Substance Use Disorder clinical evaluation (screening and referral to include comorbidity).</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<th>G. HIV/AIDS brief risk intervention for the chemically dependent.</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<th>H. Substance Use Disorder treatment planning.</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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<tr>
<td>Course Title</td>
<td>Number</td>
<td>Semester Credits</td>
<td>Quarter Credits</td>
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</table>

I. Referral and use of community resources.

J. Service coordination.
(Implementing the treatment plan, consulting, continuing assessment and treatment planning).

K. Individual counseling.

L. Group counseling.

M. Substance Use Disorder counseling for families, couples, and significant others.

N. Client, family and community education.

O. Developmental psychology.

P. Psychopathology/abnormal psychology.

Q. Documentation, to include, screening, intake, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client related data.

R. Substance Use Disorder confidentiality.

S. Professional and ethical responsibilities.
### T. Relapse prevention.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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### U. Adolescent Substance Use Disorder assessment and treatment.

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<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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### V. Substance Use Disorder case management.

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<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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### W. Substance Use Disorder rules and regulations.

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<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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### 7. Course Topics Identification—[WAC 246-811-077](#)

To be completed if you are applying by alternative training.

Complete this section if you hold an active license in good standing in a profession listed in [WAC 246-811-076](#) and completion of at least 15 quarter or 10 semester credits specific to alcohol and drug addicted individuals. Identify the course you took and the associated course number. One course may be used for more than one topic area.

#### A. Survey of Addiction

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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#### B. Treatment of Addiction

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<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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#### C. Pharmacology

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<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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#### D. Physiology of Addiction

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<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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#### E. American Society of Addiction Management (ASAM) Criteria

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<thead>
<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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#### F. Individual, Group, Including Family Addiction Counseling

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<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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</table>

#### G. Substance Use Disorder Law and Ethics

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<thead>
<tr>
<th>Course Title</th>
<th>Number</th>
<th>Semester Credits</th>
<th>Quarter Credits</th>
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</thead>
</table>
8. National Certification—To be completed if you are applying for alternative training

An applicant who holds an active license in good standing in a profession listed in WAC 246-811-076 may submit a proof of an approved national certification. See WAC 246-811-078 for a listing of approved national certifications.

List the approved National Certification that you hold.

___________________________________________________________________________________

9. Attestation of Recovery

Effective July 28, 2019, ESHB 1768 requires all substance use disorder professional and substance use disorder professional trainee applicants to complete the attestation of recovery form. The licensing authority uses the attestation to determine whether more information is required to process your application. Additional information may include requiring your participation in a mental, physical or psychological evaluation.

Recovery as defined in RCW 18.205.020(9), means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery often involves achieving remission from active substance use disorder.

☐ I have been in recovery since _____________________________;

☐ I do not have a substance use disorder.

(mm/dd/yyyy)

Applicant’s Initials | Date
10. Applicant’s Attestation

I, ____________________________, declare under penalty of perjury under the laws of
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)
Verification of Substance Use Disorder Professional Supervision and Experience

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

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 Substance Use Disorder 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 Substance Use Disorder 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 |  |
**Note to Supervisor:**

To be considered an **appropriate supervisor**, your qualifications must either meet or exceed the requirements of a certified Substance Use Disorder Professional in the state of Washington. You must be eligible to take the examination required for certification and have at least three-thousand hours of experience in a state approved Substance Use Disorder treatment agency. The three thousand hours are in addition to the supervised experience hours needed to be eligible to become a Substance Use Disorder professional. Twenty-eight clock hours of recognized supervised training may be substituted for one thousand hours of experience. You are not a blood or legal relative, significant other, cohabitant of the supervisee, or someone who has acted as the person supervised’s primary counselor.

**Do not sign this form verifying applicant’s hours unless you meet the criteria and can provide documentation if called upon to do so.**

My qualifications include:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

I certify the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if needed, to evaluate the application of the individual named on this document. I also attest that I meet or exceed the educational and supervision requirements for certification (as required by WAC 246-811-049).

________________________________________________________  ________________________________
Signature of Supervisor Date

Please return this form directly to the address above.
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  
Substance Use Disorder Professional Laws, RCW 18.205  
Substance Use Disorder Professional Rules, WAC 246-811  
Standards of Professional Conduct, WAC 246-16

**Online**

Substance Use Disorder Professional Program, Web Page

Get important information about your credential type by subscribing to email alerts.