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: _____

_____

_____

_____

_____

Seal

Acting In Behalf of the:

Official Name Board _____

Phone _____

Secretary_____

Date Certification Prepared_____