Substance Use Disorder Professional Certification Application Packet

Contents:

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:

Substance Use Disorder 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 (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. 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.
- 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. 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.

☐ **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.

Washington State Department of Health

Date Stamp Here

Revenue: 0207060000

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

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. 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.

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.)

	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

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

State	License/Certification/Registration Type	License/Certification/Registration		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grand Fathered

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.

School	Degree	Major	Date degree granted

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: _____

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.

A. Understanding addiction.

Course Title	Number	Semester Credits	Quarter Credits

B. Pharmacological actions of alcohol and other drugs.

Course Title	Number	Semester Credits	Quarter Credits

C. Substance abuse and addiction treatment methods.

Course Title	Number	Semester Credits	Quarter Credits

D. Understanding addiction placement, continuing care, and discharge criteria, including ASAM criteria.

Course Title	Number	Semester Credits	Quarter Credits

E. Cultural diversity including people with disabilities and its implication for treatment.

Course Title	Number	Semester Credits	Quarter Credits

F. Substance Use Disorder clinical evaluation (screening and referral to include comorbidity).

Course Title	Number	Semester Credits	Quarter Credits

G. HIV/AIDS brief risk intervention for the chemically dependent.

Course Title	Number	Semester Credits	Quarter Credits

H. Substance Use Disorder treatment planning.

Course Title	Number	Semester Credits	Quarter Credits

I. Referral and use of community resources.

Course Title	Number	Semester Credits	Quarter Credits

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

Course Title	Number	Semester Credits	Quarter Credits

K. Individual counseling.

Course Title	Number	Semester Credits	Quarter Credits

L. Group counseling.

Course Title	Number	Semester Credits	Quarter Credits

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

Course Title	Number	Semester Credits	Quarter Credits

N. Client, family and community education.

Course Title	Number	Semester Credits	Quarter Credits

O. Developmental psychology.

Course Title	Number	Semester Credits	Quarter Credits

P. Psychopathology/abnormal psychology.

Course Title	Number	Semester Credits	Quarter Credits

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

Course Title	Number	Semester Credits	Quarter Credits

R. Substance Use Disorder confidentiality.

Course Title	Number	Semester Credits	Quarter Credits

S. Professional and ethical responsibilities.

Course Title	Number	Semester Credits	Quarter Credits

T. Relapse prevention.

Course Title	Number	Semester Credits	Quarter Credits

U. Adolescent Substance Use Disorder assessment and treatment.

Course Title	Number	Semester Credits	Quarter Credits

V. Substance Use Disorder case management.

Course Title	Number	Semester Credits	Quarter Credits

W. Substance Use Disorder rules and regulations.

Course Title	Number	Semester Credits	Quarter Credits

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

Course Title	Number	Semester Credits	Quarter Credits

B. Treatment of Addiction

Course Title	Number	Semester Credits	Quarter Credits

C. Pharmacology

Course Title	Number	Semester Credits	Quarter Credits

D. Physiology of Addiction

Course Title	Number	Semester Credits	Quarter Credits

E. American Society of Addiction Management (ASAM) Criteria

Course Title	Number	Semester Credits	Quarter Credits

F. Individual, Group, Including Family Addiction Counseling

Course Title	Number	Semester Credits	Quarter Credits

G. Substance Use Disorder Law and Ethics

Course Title	Number	Semester Credits	Quarter Credits

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. 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.

Applicant's Initials	Date

10. 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
Substance Use Disorder Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

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	

Washington State Department of Health
Substance Use Disorder Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Substance Use Disorder Professional Statement of Qualifications

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 four-thousand hours of experience in a state approved Substance Use Disorder treatment agency. The four 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.

Washington State Department of Health
Substance Use Disorder Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Attestation of Recovery

This application will be used by the licensing authority to decide whether more information is needed 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(6), 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 _____;
(mm/dd/yyyy)

☐ I do not have a substance use disorder.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed on the _____ day of _____, _____ at _____
(date) (month) (year) (city or other location, and state or country)

_____
(Printed Name)

_____
(Signature)

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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

AIDS Training Resources, Reference Page

Substance Use Disorder Professional Program, Web Page

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