



Office of Customer Service
PO Box 47865
Olympia WA, 98504-7865
360-236-4700

Substance Use Disorder Professional Trainee Declaration of Approved Education Program

Name of Practitioner:
Credential Number:
I declare that I am enrolled in an approved education program or have completed the educational requirements and am actively pursuing the experience requirements in RCW 18.205.090 .
Signature of Practitioner:
Date:

Mail this document with your check or money order to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Documents without a check or money order:

Department of Health
Office of Customer Service
PO Box 47865
Olympia, WA 98504-7865

If you have any questions, please contact the Health Systems Quality Assurance Division, Customer Service Center.

Phone: 360-236-4700

Fax: 360-236-4818

Email: hsqarenewalresearch@doh.wa.gov