

**APPLICATION  
CERTIFIED CO-OCCURRING DISORDERS PROFESSIONAL-DIPLOMATE**

Please type or print in ink.

1. Name: \_\_\_\_\_  
(As you wish it to appear on your certificate)

2. Home Address: \_\_\_\_\_  
Street/P.O. Box  
\_\_\_\_\_  
City/State/Zip Code

3. Home Phone: \_\_\_\_\_

4. Email: \_\_\_\_\_

5. Social Security Number: \_\_\_\_\_

6. What language(s) are you fluent in other than English? \_\_\_\_\_

7. What is your ethnicity? (Optional -- research purposes only)

- |                         |                             |
|-------------------------|-----------------------------|
| ___ (1) Alaskan Native  | ___ (14) Micronesian        |
| ___ (2) American Indian | ___ (15) Samoan             |
| ___ (3) Cambodian       | ___ (16) Tongan             |
| ___ (4) Chinese         | ___ (17) Other Pacific Isle |
| ___ (5) Filipino        | ___ (18) African American   |
| ___ (6) Japanese        | ___ (19) Caucasian          |
| ___ (7) Korean          | ___ (20) Portuguese         |
| ___ (8) Laotian         | ___ (21) Cuban              |
| ___ (9) Okinawan        | ___ (22) Mexican            |
| ___ (10) Other Asian    | ___ (23) Puerto Rican       |
| ___ (11) Fijian         | ___ (24) Other Hispanic     |
| ___ (12) Hawaiian       | ___ (25) Mixed              |
| ___ (13) Part Hawaiian  | ___ (26) Other Specify      |

**FOR OFFICIAL USE ONLY**

Fee Amount: \_\_\_\_\_ Transcripts: \_\_\_\_\_

Date Received: \_\_\_\_\_ Supervisor Forms: \_\_\_\_\_

Code of Ethics: \_\_\_\_\_

DBASE: \_\_\_\_\_ Background Check: \_\_\_\_\_

## EDUCATION AND CERTIFICATION INFORMATION

I have requested that official transcripts be sent to ADAD:                    YES                    NO

## CO-OCCURRING DISORDER WORK HISTORY

Work history must be verified through the enclosed Work Experience Verification Record.

(Resume may substitute for this work history)

Start with your present employer, or if unemployed, your last employer and list your employment record in **REVERSE CHRONOLOGICAL** order. You must provide sufficient information to clearly document supervised work experience specific to criminal justice addiction. You may attach job descriptions or other relevant materials to provide further clarification. **INFORMATION WHICH CANNOT BE VERIFIED WILL NOT BE ACCEPTED.**

Indicate your employment status for each position as full-time (40 hours or more per week); part-time (less than 40 hours per week); Intern (position within a structured training program); or volunteer (unpaid position). **IF YOU ARE WORKING AS A VOLUNTEER, YOU MUST ATTACH A JOB DESCRIPTION FROM YOUR EMPLOYER.**

<b>EMPLOYER:</b>	<b>DATES OF EMPLOYMENT:</b>  <b>FROM:</b> <b>TO:</b>
<b>EMPLOYER'S ADDRESS:</b>	<b>AVERAGE NUMBER OF HOURS WORKED PER WEEK:</b>
<b>SUPERVISOR'S NAME:</b>	<b>SUPERVISOR'S PHONE NUMBER:</b>
<b>EMPLOYMENT STATUS, DUTIES &amp; RESPONSIBILITIES:</b>	<b>PERCENT OF YOUR TIME SPENT IN PROVIDING CO-OCCURRING DISORDER WORK:</b>

<b>EMPLOYER:</b>	<b>DATES OF EMPLOYMENT:</b>  <b>FROM:</b> <b>TO:</b>
<b>EMPLOYER'S ADDRESS:</b>	<b>AVERAGE NUMBER OF HOURS WORKED PER WEEK:</b>
<b>SUPERVISOR'S NAME:</b>	<b>SUPERVISOR'S PHONE NUMBER:</b>
<b>EMPLOYMENT STATUS, DUTIES &amp; RESPONSIBILITIES:</b>	<b>PERCENT OF YOUR TIME SPENT IN PROVIDING CO-OCCURRING DISORDER WORK:</b>

<b>EMPLOYER:</b>	<b>DATES OF EMPLOYMENT:</b>  <b>FROM:</b> <b>TO:</b>
<b>EMPLOYER'S ADDRESS:</b>	<b>AVERAGE NUMBER OF HOURS WORKED PER WEEK:</b>
<b>SUPERVISOR'S NAME:</b>	<b>SUPERVISOR'S PHONE NUMBER:</b>
<b>EMPLOYMENT STATUS, DUTIES &amp; RESPONSIBILITIES:</b>	<b>PERCENT OF YOUR TIME SPENT IN PROVIDING CO-OCCURRING DISORDER WORK:</b>

This form may be reproduced, as needed, to complete your work history.

Have you at any time, been the subject of a finding of unethical, unprofessional, or illegal conduct made as part of a final decision by a regulatory body (e.g. certification or licensing board) or by a court (civil or criminal)?

\_\_\_\_\_YES      \_\_\_\_\_No (If yes, attach an explanation and copies of official documents.)

“I hereby certify that all of the information given herein and on any attachment is true and complete to the best of my knowledge. I also authorize any necessary investigations and the release of personal information to the Alcohol and Drug Abuse Division (ADAD). I understand that falsification of any portion of this application or attachments may result in the revocation of this application.

I further agree to hold the Department of Health, Alcohol and Drug Abuse Division agents, staff and examiners free from any civil liability for damages or complaints about any action within the scope and arising out of the performance of their duties and which is taken in connection with this application, the examinations, grades received on examinations, and/or the failure of the Division to issue me a certificate.”

\_\_\_\_\_  
Applicant’s Name (PRINT IN INK)

\_\_\_\_\_  
Applicant’s Signature (SIGN IN INK)      \_\_\_\_\_  
Date

\*\* You must sign the “Code of Ethics Statement” which is included in this packet. Unsigned or incomplete applications will not be processed.

### **RECORD STORAGE**

The Alcohol and Drug Abuse Division maintains records on all applicants for Certified Co-Occurring Disorders Professional-Diplomate. Inactive records are archived for three (3) years from date of last correspondence and may be destroyed after three (3) years from the date of last correspondence. Therefore, it is important to keep ADAD informed of any address change.