Certification Application

First Name, Middle Initial:		Last Name:			
Previous Names:					
DOB:		SSN:			
Home Address					
City:		State:	Zip:	Island:	
Email:			Alternative Email:		
Phone #:			Other Phone#		
Gender:		Legal/Civil/Disciplinary Action(s): **ADAD will conduct a full background check.**	Yes ☐	No ☐	

If yes is indicated on the Legal/Civil/Disciplinary Actions, please send in documentation as indicated

Ethnicity	☐ Alaskan Native ☐ American Indian ☐Cambodian ☐ Chinese ☐ Filipino ☐Japanese ☐Korean ☐Laotian ☐ Okinawan ☐Other Asian ☐Fijian ☐Hawaiian ☐ Part Hawaiian ☐ Micronesian ☐ Samoan ☐Tongan ☐ Other Pacific Isle ☐ African American ☐Caucasian ☐ Portuguese ☐Cuban ☐Mexican ☐ Puerto Rican ☐Other Hispanic ☐ Mixed, ☐Other, specify	
Languages	Please indicate other language (s) fluent in other than English	
Current Employment	Employer Name:	Contact Number:
	Address:	
	Is this a substance abuse facility? Yes ☐ No ☐ If No, please explain:	
	Applicant Position/Title:	
	Hire Date in Current Position:	How many hours do you work per week?
Current Supervisor Information	Immediate Supervisor:	
	Supervisor Position/Title:	
	Email:	Phone:

Previous Employer	Name of Employer:	Supervisor:
Previous Employer Contact Information:		
Previous Job Title:		
Reason for leaving: Can we contact previous employer: Yes ☐ No ☐		
Previous Employer	Name of Employer:	Supervisor:
Previous Job Title:		
Reason for leaving: Can we contact previous employer: Yes ☐ No ☐		
Education		
Highest Level Degree Complete:		
Name on Transcript		
Other License or Certificates :		

I am applying for a CSAC with a :

HS Diploma	***Certificate in SUD/Bachelors/Masters***	***License SW, MFT,MH***	***License Physician, Psychologist/Psychiatrist/APR***
☐			

Reminder, if you are applying with a license, you are not eligible for reciprocity and oversight for a candidate in the future of the 12 Core Functions. If applying with a license, please submit your license with your application.

Reference :

Name:	***Contact Number:***	***Relationship:***
Name:	***Contact Number:***	***Relationship:***
Name:	***Contact Number:***	***Relationship:***

This page must be completed by the applicant and must be submitted with the application.

RELEASE

I request that the Alcohol and Drug Abuse Division (ADAD) grant the credential to me based on the following assurance and documentation:

- I subscribe to and commit myself to professional conduct in keeping with the CSAC Code of Ethics; I also verify that I have no prior disciplinary actions for other profession certification/license within or outside of the State of Hawaii.
- ***Sign Here as Acknowledgment of the Code of Ethics:*** _____

Date:

- I certify that the information given herein is true and complete to the best of my knowledge and belief. I also authorize any necessary investigation and the release of information relative to my credential. Falsification of any documents will nullify this application and will result in denial or revocation of certification;
- I consent to the release of information contain in my application and other pertinent date submitted to or collect by ADAD;
- I consent to authorize ADAD to gather information from third parties regarding education and employment and understand that such communication shall be treated as confidential.
- Allegations of ethical misconduct reported to ADAD before, during, or after application for certification is made will be investigated by ADAD and could result in nullification of the application or denial or revocation of the certification.

Initial Each Statement:

	I have read and understood the Release
	I either live or work in the State of Hawaii at least 51% of the time
	I understand the application fee in nonrefundable if application is denied or cancelled prior to the examination and no refund will be issued if application is denied or called after examination
	I understand that my application is open for a period of seven (7) years after the date of review, providing there is activity towards progression and/or two (2) years with no activity. If no activity is done within in 2 (two) years my file will be closed.
	I understand that it is my responsibility to work with my supervisor on work verification hours.
	I understand if my current job changes, I need to submit a new job description.
	I understand that if I have a new supervisor, the supervisors job description needs to be submitted.

Applicant Signature: _____ ***Date:***

Administrative Only:
Fee Received:_____
Background Check:_____
Ethics:_____
Transcript:_____
Job Description:_____
ID:_____