Application for Certification

INSTRUCTIONS: ***Please complete this application form in its entirety and sign in ink.***

Certification Applying For:
(Choose only one)

- ☐ **Certified Substance Abuse Counselor (CSAC)**
- ☐ **Certified Substance Abuse Counselor (CSAC) with License**
  (LCSW, LMFT, APRN, LMHC, Licensed Psychologist, MD)
- ☐ **Certified Prevention Specialist (CPS)**
- ☐ **Certified Clinical Supervisor (CCS)**
- ☐ **Certified Criminal Justice Addictions Professional (CCJP)**
- ☐ **Certified Substance Abuse Program Administrators (CSAPA)**

Last Name:	*First Name:*	*Middle Initial:*
Previous Names:		
Date of Birth (DOB):	*Gender:*	*Social Security Number (SSN):*

Home Address (Street/ P.O. Box):			
City:	*State:*	*Zip:*	*Island:*
Phone Number:	*Other Phone Number*		
Email:	*Alternate Email:*		

Legal/ Civil Convictions and Disciplinary Actions? ☐ **No** ☐ **Yes***

ADAD will conduct a full background check.

***If YES is indicated on the Legal/ Civil Convictions and Disciplinary Actions, please attach documentation as indicated.**

Ethnicity ***(Select all that apply)***

☐ Alaskan Native	☐ American Indian	☐ Cambodian	☐ Chinese
☐ Filipino	☐ Japanese	☐ Korean	☐ Laotian
☐ Okinawan	☐ Other Asian	☐ Fijian	☐ Micronesian
☐ Hawaiian	☐ Part-Hawaiian	☐ Samoan	☐ Tongan
☐ Other Pac. Islander	☐ African American	☐ Caucasian	☐ Portuguese
☐ Cuban	☐ Mexican	☐ Puerto Rican	☐ Other Hispanic
☐ Mixed	☐ Other (Specify): _____		

Language Skills

Not including the English language, please list other language(s) you are fluent in:

Education

I am applying with a:

- ☐ High School Diploma
- ☐ Certificate of Completion in Substance Use Disorder
- ☐ Associate's, Bachelor's or Master's Degree
- ☐ Licensed SW, MFT or MH*
- ☐ Licensed Physician, Psychologist, Psychiatrist or APR*

* ***For CSAC Applicants, if you are applying with a license, you will not be eligible for reciprocity and oversight of a candidate in the 12 Core Functions.***

Please attach a copy of your current license with this application.

Degree Completed & Area of Study: _____

Name on Transcript: _____

Other Licenses and/ or Certifications: _____

Employment

Current Employer Name:			***Contact Number:***
Current Position/ Title:			***Hire Date in Current Position:***
Address:			
City:	***State:***	***ZIP:***	***Hours Worked Per Week:***

Is this a Substance Use Disorder facility? ☐ Yes ☐ No: ****(Explain if "No"):***

Immediate Supervisor Name:	***Supervisor Position/ Title:***
Supervisor Email:	***Supervisor Phone:***

Previous Employer Name:			***May We Contact Employer?*** ☐ Yes ☐ No
Previous Position/ Title:		***Reason for Leaving:***	
Previous Supervisor:	***Phone Number:***	***Start Date of Employment:***	***End Date of Employment:***
Previous Employer Address, City, State & ZIP:			

Employment - Continued

Previous Employer Name:			*May We Contact Employer?* ☐ Yes ☐ No
Previous Position/ Title:		*Reason for Leaving:*	
Previous Supervisor:	*Phone Number:*	*Start Date of Employment:*	*End Date of Employment:*
Previous Employer Address, City, State & ZIP:			

References

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

Release

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

- 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 contained in my application and other pertinent data submitted to or collected 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 may result in nullification of the application, or denial or revocation of the certification.

Ethics Acknowledgement

I subscribe to and commit myself to professional conduct in keeping with the Code of Ethics for the certification being applied for, and in accordance with Hawaii Administrative Rules (HAR) 11-177.1, Subchapter 3. I also verify that I have no prior disciplinary actions for other professional certification(s) and/ or licenses within or outside of the State of Hawaii.

✘ _____ _____

Applicant Signature *Date*

Initial Each Statement:

_____ I have read and understood the Release.

_____ I have *SIGNED* and *DATED* the Ethics Acknowledgement.

_____ I either live or work in the State of Hawaii at least 51% of the time.

_____ I understand that the application fee is non-refundable. No refund will be issued if the application is denied or cancelled prior to the examination, or if the application is denied or recalled after the examination.

_____ I understand that my application is open for a period of seven (7) years after the date of review, providing there is activity toward progression, and/ or two (2) years with no activity. If no activity is done within two (2) years, my file will be closed.

_____ I understand that it is my responsibility to work with my supervisor on work verification hours.

_____ I understand that if my current job changes, I need to submit a new job description.

_____ I understand that if I have a new supervisor, the supervisor's job description needs to be submitted.

✘ _____ _____

Applicant Signature ***Date***

FAILURE TO SUBMIT REQUIRED DOCUMENTATION MAY RESULT IN REJECTION OF YOUR APPLICATION AND/ OR HINDERANCE OF THE REVIEW PROCESS.

Did You Remember to…

- ☐ Read and review the application instructions for the certification you are applying for?
- ☐ Fill out the application completely?
- ☐ Sign and date the Ethics Acknowledgement (page 3)?
- ☐ Initial each statement, and sign and date the application (page 4)?
- ☐ Submit a non-refundable fee payment in the form of a **cashier's check** or **money order**, made payable to the ***State Director of Finance***? If paying with a money order, it must be purchased within 30-days of submission. There is a $25.00 service fee for returned checks or money orders.
- ☐ Attach a copy of your Job Description?
- ☐ Attach a copy of your valid government-issued photo ID?
- ☐ Attach documents related to any Legal/ Civil Convictions and/or Disciplinary Action documents, if applicable?
- ☐ *For CSAPA applicants ONLY* – Attach resume as a substance abuse program administrator with corresponding job descriptions, and letter of reference from CEO or Chairman of the Board for where you are/ were most recently employed as a program administrator?
- ☐ Mail to: **The Alcohol and Drug Abuse Division**
  Quality Assurance and Improvement Office
  601 Kamokila Boulevard, Room 360
  Kapolei, Hawaii 96707

Administrative Use Only:

Fee Amount:		**CCS, CCJP & CPS**	
Date Received:		Work History/ Resume Received:	
Valid ID Received:			
Job Description Received:		**CSAPA**	
Transcript Received:		Resume Received:	
Background Check:		Job Descriptions Received:	
Database Number#:		Letter of Reference Received:	