

FOR OFFICE USE ONLY



Receipt #

ID #

Issue Date

License #

Rhode Island Board of Licensing for Chemical Dependency Professionals

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for:

- Chemical Dependency Professional
- Chemical Dependency Clinical Supervisor

MILITARY STATUS ELIGIBILITY

*(Documentation Required)
see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME

FIRST NAME

MI

Phone: (401) 222-2828

TTY/TDD: (800) 745-5555

Fax: (401) 222-1272

LICENSURE REQUIREMENTS

- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$75.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- Birth Certificate (**official certified copy**), or if born outside the United States, proof of citizenship, lawful alien status or legal entry.
- Copy of current Certification at the appropriate-cite level.
- If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information.

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



State of Rhode Island Board of Licensing for Chemical Dependency Professionals

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., Dr., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

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U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

3. Gender

 Male Female

4. Date of Birth

 / /

Month

Day

Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

 -

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 -

Home Phone

 -

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

 -

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 -

Business Phone

Extension

 -

Business Fax

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| 7. Preferred Mailing Address Please check <u>ONE</u> | <input type="checkbox"/> Please use my Home Address as my preferred mailing address <input type="checkbox"/> Please use my Business Address as my preferred mailing address |
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|---|---|
| 8. Disciplinary Questions Check either Yes or No for each question. | <p>1. Have you ever been sanctioned by the National Association of Alcohol and Drug Abuse Counselors, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse board? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>2. Have you ever been declared mentally incompetent by any court? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>3. Have you ever been convicted of a felony violation of any state or federal law? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>4. Have you been impaired by any controlled substance or any alcoholic beverage to the extent that the use impairs your ability to practice the profession that is authorized by this license? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>NOTE: If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter. If necessary, you may continue on a separate 8½ x 11 sheet of paper.</p> |
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| 9. Affidavit of Applicant Complete this section and sign. Make sure that you have completed all components accurately and completely. | <p>I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.</p> <p>I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Chemical Dependency Professionals any information which is material to my application for licensure.</p> <p>I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license in the State of Rhode Island.</p> <p>I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Chemical Dependency Professionals of any change in the answers to these questions after this application and this affidavit is signed.</p> <p>_____ Signature of Applicant</p> <p>_____ Date of Signature (MM/DD/YY)</p> |
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