Application for Reciprocity

DO NOT FAX THIS APPLICATION

This completed form, the documentation required for reciprocity should be mailed to the address below. You must allow for at least two weeks for the application to be processed. Your application will be cross referenced with other certifying organizations.

CADTP will grant reciprocity to AOD counselors who meet the following criteria (please check one) and provide documentation of such:

☐ I am certified or registered by one of the certifying organizations approved by the California Department of Alcohol and Drug Programs (DHCS), as listed in Chapter 8, Division 4, Title 9, California Code of Regulations, my certification is current (unexpired) and I would like to recertify with CADTP, (copy of certificate/registration must be attached).

☐ I was previously **certified by one of the certifying organizations approved by the DHCS,** my certification has lapsed (expired) less than two years, I would like to apply for CADTP certification (copy of certificate must be attached). $125 renewal fee & renewal form are required (separate form: see INITIAL CERTIFICATION APPLICATION form on our website).

☐ I am certified or licensed in another state, my certification or license is current and I would like to apply for certification without requiring testing. I have attached documentation that my current certification or license meets or exceeds CADTP's eligibility criteria. $150 application fee is required.

You **MUST** include the following in your application:

☐ Signed Code of Ethics (Separate sheet)

☐ Copy of current certification/registration & any required supplemental forms/fees

☐ Copy of State ID or Driver License - must be a clean copy in which the picture is recognizable

Please type or print legibly:

Full Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ E-Mail: _____

ID or Driver License #: _____ State: _____ SSN (last 4 numbers) _____

Employer (If Any): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

By signing below, I am confirming that I have not been suspended or revoked by the California Department of Health Care Services nor any other certifying organization*. Further, I understand that I am obligated to report any suspension or revocation by another certifying organization to CADTP. I also acknowledge having received a copy of the current California Department of Health Care Services (DHCS) (formerly, ADP - Department of Alcohol & Drug Programs) Uniform Code of Conduct and the CADTP Code of Ethics and agree to adhere to both. I have enclosed a signed copy with this application.

Your Signature: _____ Date: _____

Required

*Will be verified

1731 Howe Ave., PMB #352 | Sacramento, CA 95825

Phone: (800) 464-3597 | Fax: (866) 621-2286

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