



Registration Renewal Form

Beginning January 1, 2017, all CADTP Registrants must renew annually and meet the renewal criteria. Renewal requires this completed form, the documentation required (see checklist below) and a check, money order or Visa/MasterCard payment in the amount of \$25. You must submit proof that you have been attending a college course towards your certification of at least 40 hours (3 units equal 45 hours) of AOD education courses in the past 12 months; up to 315 hours. This proof must be transcripts (may be unofficial for this purpose); or you must get an official letter from your school if you are attending a post-secondary college that doesn't issue transcripts. Visit www.cadtp.org/certification-overview for course requirements.

Please include the following in your renewal application:

- Signed Uniform Code of Conduct; CADTP Code of Ethics**
- 3 hours of Ethics Continuing Education**
- 3 hours of Confidentiality Continuing Education**
- Payment of \$25**
- Proof of at least 40 hours (3 units) of AOD education courses in the past 12 months, or if AOD educational requirements have been met proof of progress in the past 12 months towards meeting the working hours requirement,**
- Renewal Form Completed**

Your Expiration Date:		Your 5-year maximum registration Date:	
1. Name: Last		First	Middle
2. Full Street Address:		City:	State: Zip Code:
3. College Attending (Name and Location):		4. Hours/units of College Education Earned in past 12 Months (submit transcripts/letter):	
5. Email Address (Required if you don't have one you can get one free from many providers online):			
8. Alcohol and/or Other Drug Counseling Employer – attach additional sheets if necessary. Write/type none if not currently employed			
9. Address:	City/State/Zip	Telephone No.:	Date(s): From: _____ To: _____ <small>Month/Year Month/Year</small>
11. Have you ever been denied, suspended or revoked by DHCS or another certifying organization? If so, please list details. YES <input type="checkbox"/> NO <input type="checkbox"/>			
By signing below, I am confirming all information is correct and that I have never been suspended or revoked by any other certifying organization. Further, I understand that I am obligated to report any suspension or revocation by DHCS or another certifying organization to CADTP. I also agree to adhere to the California State Department of Health Care Services (DHCS) Uniform Code of Conduct and the CADTP Code of Ethics. I understand that fees associated with this application are non-refundable.			
Signature of Applicant:		Date:	

Please allow 30 days to process
Mail, fax or email your completed application, all required documents & fee to:

CADTP
1026 W. El Norte Pkwy PMB 143 Escondido CA 92026
Phone: (800) 464-3597 | Fax: (866) 621-2286
www.cadtp.org | info@cadtp.org



**Use this form only if paying by credit card.
CADTP will not keep your credit card information on file. This page will be destroyed after
processing your payment.**

CREDIT CARD INFORMATION
Visa or MasterCard Only

Please type or print legibly:

Full Name (as it appears on the card): _____

Company Name (If using company card): _____

Complete Billing address: _____
Street number and name, City, State and Zip Code are required

Credit Card Number: _____

Expiration Date: _____ Card ID Number*: _____ Total Amount to be charged: \$ _____

*Card ID Number appears on the reverse side of the card as the last 3 numbers near the signature

Authorized Signature: _____

Daytime Phone Number (in case there is a question): _____