

NEW CERTIFICATION APPLICATION FOR ADDICTION COUNSELORS

Section 4. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)

Section 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

APARTMENT SUITE FLOOR PO BOX NUMBER

<input type="text"/>
HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

<input type="text"/>
HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

<input type="text"/>
CITY

<input type="text"/>	<input type="text"/>	-	<input type="text"/>
STATE	ZIP CODE + 4		

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
HOME PHONE NUMBER		HOME FAX NUMBER		

<input type="text"/>
E-MAIL ADDRESS

Section 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

<input type="text"/>
COMPANY NAME

APARTMENT SUITE FLOOR PO BOX NUMBER

<input type="text"/>
BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

<input type="text"/>
BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

<input type="text"/>
CITY

<input type="text"/>	<input type="text"/>	-	<input type="text"/>
STATE	ZIP CODE + 4		

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
BUSINESS PHONE NUMBER		BUSINESS FAX NUMBER		

<input type="text"/>
E-MAIL ADDRESS

5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future registration documents will be mailed. The address that will appear on your registration will be your business address.

HOME BUSINESS

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION

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SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an “X” in the appropriate boxes. If you answer “Yes” to questions B through J below, you must provide full information and complete details **on a separate sheet of paper, including copies of relevant court documents**, and attach to this application.

Clean Hands Before Receiving a Registration or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your Registration or Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER “YES” TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

- A.
1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
 4. Past due taxes;
 5. Past due District of Columbia Water and Sewer Authority service fees; or
 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your application for registration or permit under the *Clean Hands Before Receiving a Registration or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

Y N

B. Have you ever been convicted or arrested for a crime (including misdemeanors) not previously reported to the Board?	YES NO <input type="checkbox"/> <input type="checkbox"/>
C. Are you now or have you ever been registered, certified or licensed in DC or any other state/jurisdiction? (<i>If "Yes," be sure to complete section 6C of this form.</i>)	YES NO <input type="checkbox"/> <input type="checkbox"/>
D. Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES NO <input type="checkbox"/> <input type="checkbox"/>
E. Have you ever voluntarily surrendered a registration, certification or license after formal charges have been filed against you or while under investigation?	YES NO <input type="checkbox"/> <input type="checkbox"/>
F. Have you ever been terminated from or resigned from a clinical or professional training program?	YES NO <input type="checkbox"/> <input type="checkbox"/>
G. Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES NO <input type="checkbox"/> <input type="checkbox"/>
H. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES NO <input type="checkbox"/> <input type="checkbox"/>
I. (1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your registration, license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES NO <input type="checkbox"/> <input type="checkbox"/> YES NO <input type="checkbox"/> <input type="checkbox"/> YES NO <input type="checkbox"/> <input type="checkbox"/> YES NO <input type="checkbox"/> <input type="checkbox"/>
J. Are you or have you been in jail on a felony conviction?	YES NO <input type="checkbox"/> <input type="checkbox"/>
K. Have you ever been terminated or asked to resign from employment since obtaining your (professional) registration, certification and/or license?	YES NO <input type="checkbox"/> <input type="checkbox"/>

SECTION 8. APPLICANT AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

APPLICANT SIGNATURE

NAME (Please Print)

DATE