



California SUD Counselor Certification

Initial Registration Application

Required Registration

Regulations adopted by the California Department of Health Care Services. (DHCS), as effective April 1, 2005, require individuals who are not licensed professionals or who have not been previously certified, as specified in the regulations, to register with one of the designated certifying organizations listed on DHCS website.

Applicants for registration are required to complete a 9-hour orientation class prior to registration, consisting of 3 hours of SUD Ethics, 3 hours of SUD Confidentiality and 3 hours of SUD Professional Boundaries. This can be done in a single combined class on the three subjects. Submit official proof of attendance with this application.

Please note that the regulations allow employers to determine which of the certifying organization certifications they will accept. Potential registrants are advised to check with their employer, if any, before registering.

Registration is not equivalent to and is not an alternative to certification. Once you are registered you must complete the requirements for certification within five years. Your application will be cross referenced with other certifying organizations, if you are/were previously registered elsewhere, please indicate so on the application.

Certification

CADTP'S Substance Use Disorder Certified Counselor (SUDCC) credentials are designed to ensure a satisfactory level of competence for counselors working in SUD treatment programs. The Substance Use Disorder Certified Counselor certification has been developed to assess the knowledge and skills directly related to providing substance use disorder counseling services. SUDCC certification demonstrates that the certificant has the skills and experience needed to serve their clients and provides competency assurance to employers and the public.

Details of certification procedures, education, experience, and testing requirements as well as application forms can be found on the CADTP.ORG website.

Please submit the attached application, leaving nothing out and no blanks to become registered. Allow 2-3 weeks for processing. Incomplete applications will be returned and must be resubmitted.



CADTP

1026 W. El Norte Pkwy PMB 143

Escondido CA 92026

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

Email: info@cadtp.org Website: www.cadtpcounselors.org

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DO NOT FAX THIS APPLICATION

This completed form, the documentation required for registration and a check, money order or the completed credit card information below in the amount of seventy-five dollars (\$75) should be mailed or emailed to the address below.

Please include the following in your registration application:

- Payment of \$75
- Official Certificate – 9 Hour Orientation Course
- 2” x 2” passport style photograph of applicant
- Copy of official ID (Driver’s license)
- Uniform Code of Conduct; CADTP Code of Ethics - signed, dated and each page initialed; (Separate form)
- I was/am registered with* _____ On _____

Please type or print legibly:

First name: _____ Middle Name: _____ Last Name: _____

FULL mailing address: _____
Street number and name, City, State, and Zip Code are required

Last 4 of SSN (required): _____ Driver’s License #: _____ Phone: _____

E-Mail (required): _____

Employer (If Any): _____

Employer address: _____

I certify that this is my initial application for registration to become a Certified Substance Use Disorder counselor in the State of California pursuant to Section 13035 (f), Chapter 8, Division 4, Title 9, California Code of Regulations, and that I have not previously applied for registration by any other Certifying Organization approved by the State of California Department of Health Care Services.

By signing below, I am confirming that I have not been suspended or revoked by any other certifying organization or the Department of Health Care Services*. 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 Department of Health Care Services (DHCS) 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



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CREDIT CARD INFORMATION (Master Card or Visa Only)

The information below will be shredded after your card has been charged; we do not keep your credit card information on file.

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

Total Amount to be charged: \$ _____

Authorized Signature: _____

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



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