

**APPLICATION**  
**CERTIFIED SUBSTANCE ABUSE COUNSELOR (CSAC)**  
(Please type or print in ink)

1. Name: \_\_\_\_\_  
(As you wish it to appear on your certificate)

2. Home Address: \_\_\_\_\_  
Street/P.O. Box

\_\_\_\_\_  
City/State Zip Code

3. Home Phone: \_\_\_\_\_  
Area Code & Number

4. Email: \_\_\_\_\_

5. Social Security Number: \_\_\_\_\_

6. What language(s) are you fluent in other than English? \_\_\_\_\_

7. What is your ethnicity? (Optional--research purposes only)

- |                       |                           |
|-----------------------|---------------------------|
| — (1) Alaskan Native  | — (14) Micronesian        |
| — (2) American Indian | — (15) Samoan             |
| — (3) Cambodian       | — (16) Tongan             |
| — (4) Chinese         | — (17) Other Pacific Isle |
| — (5) Filipino        | — (18) African American   |
| — (6) Japanese        | — (19) Caucasian          |
| — (7) Korean          | — (20) Portuguese         |
| — (8) Laotian         | — (21) Cuban              |
| — (9) Okinawan        | — (22) Mexican            |
| — (10) Other Asian    | — (23) Puerto Rican       |
| — (11) Fijian         | — (24) Other Hispanic     |
| — (12) Hawaiian       | — (25) Mixed              |
| — (13) Part-Hawaiian  | — (26) Other, Specify     |

**FOR OFFICIAL USE ONLY**

Fee Amount: \_\_\_\_\_

Transcripts: \_\_\_\_\_

Date Received: \_\_\_\_\_

Supervisor Forms: \_\_\_\_\_

Training Resume: \_\_\_\_\_

Code of Ethics: \_\_\_\_\_

DBASE: \_\_\_\_\_

**EDUCATIONAL INFORMATION**

I have a: (high school diploma or highest degree completed:) \_\_\_\_\_

In what area of study: \_\_\_\_\_

I have requested that transcripts be sent to ADAD: **YES** **NO**

**SUBSTANCE ABUSE COUNSELING WORK HISTORY**  
(Work history must be verified through the enclosed Supervisor Form)

Employer: \_\_\_\_\_  
Dates of Employment: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_  
Supervisor's Phone: \_\_\_\_\_

Employer: \_\_\_\_\_  
Dates of Employment: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_  
Supervisor's Phone: \_\_\_\_\_

Employer: \_\_\_\_\_  
Dates of Employment: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_  
Supervisor's Phone: \_\_\_\_\_

**CURRENT EMPLOYMENT**

Employer: \_\_\_\_\_  
Dates of Employment: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Have you, at any time, been the subject of a finding of unethical, unprofessional, or illegal conduct made as part of a final decision by a regulatory body (e.g. certification or licensing board) or by a court (civil or criminal)?

\_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, attach an explanation and copies of official documents.)

"I hereby certify that all of the information given herein and on any attachments is true and complete to the best of my knowledge. I understand that falsification of any portion of this application or attachments may result in the revocation of this application.

I further agree to hold the Department of Health, Alcohol and Drug Abuse Division agents, staff and examiners free from any civil liability for damages or complaints about any action within the scope and arising out of the performance of their duties and which is taken in connection with this application, the examinations, grades received on examinations, and/or the failure of the Division to issue me a certificate."

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Applicant's Name (PRINT)

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Applicant's Signature (IN INK)

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Date

\*\*You must sign the "Code of Ethics Statement" which is included in this packet. Unsigned or incomplete applications will not be processed.

### RECORD STORAGE

The Alcohol and Drug Abuse Division maintains records on all applicants and Certified Substance Abuse Counselors and Program Administrators. Inactive records are archived for three (3) years from date of last correspondence and may be destroyed after five (5) years from date of last correspondence. Therefore, it is important to keep ADAD informed of any address change.