



Dr. Frank E. Shelp, Commissioner  
Onaje Salim, Division Director

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Georgia Department of Behavioral Health & Developmental Disabilities • Division of  
Addictive Diseases  
Two Peachtree Street, NW • Suite 22.224 • Atlanta, Georgia 30303-3171 • 404-657-7857

APPLICATION FOR REGISTRY

TO

PROVIDE SERVICES TO DUI OFFENDERS

*As A*

CLINICAL EVALUATOR

*AND/OR*

TREATMENT PROVIDER

*(Who will only be providing ASAM Level I)*

DUI INTERVENTION PROGRAMS

DIVISION OF ADDICTIVE DISEASES

DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

2 Peachtree Street, NW, 22<sup>nd</sup> Floor

Atlanta, GA 30303-3171

(404) 657-6433

Equal Opportunity Employer

**NOTICE**

**TO ALL APPLICANTS**

ALL APPLICATIONS SUBMITTED TO THE DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES BECOME A PERMANENT RECORD OF THE DEPARTMENT. THEREFORE, PLEASE BE ADVISED THAT THE AGENCY CANNOT RETURN ANY PART OF THIS APPLICATION.

Please keep a copy of the application and all attachments for your file.

Please carefully read the enclosed DBHDD Rules, Clinical Evaluators and Substance Abuse Treatment for DUI Offenders (290-4-13).

Please carefully read all instructions for completing the application.

PLEASE RETURN THE APPLICATION IN ITS **ORIGINAL ORDER WITH NO DELETIONS OR ALTERATIONS.** *Any additional information required should be included as attachments. Addendum B should be sent directly to DBHDD by the person or persons verifying your work experience (if applicable).*

PLEASE BE CERTAIN THAT YOUR APPLICATION IS COMPLETE. *Complete applications are processed promptly. Incomplete applications will automatically go into pending status, and delay processing.*

APPLICATION FEES: \$100 Clinical Evaluator; \$150 Treatment Provider. *If you are applying for both you must pay \$250.00.* Please make checks payable to **Department of Behavioral Health & Developmental Disabilities.**

Applications received without the application fee will not be processed until payment is received.

THANK YOU!

# DIRECTIONS FOR COMPLETING THE APPLICATION

(Use this page as a checklist to make sure your application is complete.)

## QUALIFYING CONDITIONS FOR APPLICANTS

**Applicants with Specific  
Substance Abuse Certification**

Read and initial **this page and page 3** if you are certified as indicated.

**Applicants Requiring Documentation  
of Experience/Continuing Education:**

Read and initial **this page and page 4**

**PART I**

**Personal Information:**

Complete and include one recent photo. Initial as indicated.

**PART II**

**Professional Credentials:**

Complete and include a photocopy of EACH license and credential you wish considered. Only those credentials listed in DBHDD Rules and Regulations will be accepted. Initial as indicated.

**PART III**

**Professional Practice:**

Complete and initial where indicated.

**PART IV/SECTION I**

**Clinical Evaluator Applicants ONLY:**

Complete and include a copy of each instrument or instrument contract, your interview form or guidelines or an anonymous SA patient/client interview record sample. If you provide drug screening tests, include a copy of the laboratory contract or the request form, which is used by the lab and pre-addressed to you. Initial where indicated.

**PART IV/SECTION II**

**Treatment Provider Applicants ONLY**

Complete and attach documents 1 through 6 as indicated.  
**Initial** as indicated.

**PART V**

**Applicant's Statement of Compliance:**

**Initial, Sign and Notarize** the appropriate statement. If you are applying for both Clinical Evaluator & Treatment Provider, you must complete BOTH statements.

**PART VI**

**Registry Information:**

Complete the Registry Information for the appropriate application, Clinical Evaluator & Treatment Provider respectively. If you are applying for both, you must complete *BOTH* Registry Information forms. Initial as indicated.

**Applicants Requiring Documentation of Experience/Continuing Education.**

**Complete Addendum A**

Include copies of certificates, transcripts, or signed reports as verification. **Initial** as indicated.

**Complete Addendum B**

Arrange for the appropriate form to be completed. If you are applying for **BOTH Clinical Evaluator & Treatment Provider**, you must arrange for **BOTH** forms in Addendum B to be completed appropriately.

QUALIFYING CONDITIONS FOR APPLICANTS

**APPLICANTS WITH SPECIFIC SUBSTANCE ABUSE CERTIFICATION**

Applicants Who Hold One of the Following Certifications (A-F)

- a) Certification as an addiction medicine specialist by the American Society of Addiction Medicine; (ASAM)
- b) Certification in addiction psychiatry by the American Board of Psychiatry and Neurology; (CAP)
- c) Certification by the Georgia Addiction Counselors Association as a Certified Addiction Counselor II; (CAC II)
- d) Certification by the National Association of Alcoholism and Drug Abuse Counselors Association; (NAADAC I, NAADAC 11, NAADAC - MAC)
- e) Certification by the National Certification and Reciprocity Consortium; (NCRC, ICRC)
- f) Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders from the American Psychological Association's College of Professional Psychology; (APA-CP)

***Copies of all licenses and credentials must be included with your application.***

**TRAINING & CONTINUING EDUCATION**

**All clinical evaluators and treatment providers** listed on the registry are **required to attend either one or two days of training and orientation** as sponsored by the department within six months of being placed on the registry. You will be notified of the next available training after your application is processed.

**All clinical evaluators and treatment providers** shall complete, every two years, **20 contact hours** of continuing education in **substance abuse** approved by the department. The department will not accept more than five hours in-service training in each two-year period.

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**If you do NOT hold one of the above listed credentials continue with the next page.**

QUALIFYING CONDITIONS FOR APPLICANTS

**APPLICANTS WHO DO NOT HOLD SPECIFIC SUBSTANCE ABUSE  
CREDENTIALS**

If you are NOT certified by one of the Certifying Boards (A-F) Identified in Section II  
YOU MUST HOLD LICENSURE UNDER O.C.G.A. Title 43

As a physician, psychologist, professional counselor, social worker, marriage and family therapist, advanced practice nurse, registered nurse with a bachelor's degree in nursing, certification as an employee assistance professional.

Copies of all licenses and credentials must be included with your application.

**\*ADDENDUM A** (Form for Addendum A is included separately)

**Clinical Evaluator & Treatment Provider Applicants:**

- Document the completion of at least **20 hours** of continuing education in the field of substance abuse, with not more than five of these hours consisting of in-service training, in the **two-year period prior to application**.
- These 20 contact hours or 2 CEU's **must be substance abuse specific**, for example, Counseling the Substance Abuser, Dual Diagnoses, Adolescent Substance Abuse, Narcotic Addiction, Alcoholism and Depression, Anger and Addiction, etc.  
*Include the completed form for Addendum A and copies of all certificates or other written verification of the hours claimed, with your application.*

**\*ADDENDUM B** (form for Addendum B is included separately)

**1) Clinical Evaluator Applicants:**

Document at least **2,000 hours** of clinical experience in the **treatment** of persons who are addicted to alcohol or other drugs, with at least **500 hours** of that experience in the actual administration of substance abuse **clinical evaluations**.

**2) Treatment Provider Applicants:**

- Document at least **3,000 hours** of clinical experience in the treatment of persons who are addicted to alcohol or other drugs.
- **ADDENDUM (B) MUST BE COMPLETED BY A PROFESSIONAL WHO IS OR HAS BEEN EITHER YOUR SUPERVISOR OR COLLEAGUE AND HOLDS ONE OF THE CREDENTIALS LISTED IN RULE 290-4-13:04.**

*The completed Addendum B must be sent directly by the supervisor/colleague to the **DBHDD Office**. Completed originals included with the **application will not be accepted**.*

**TRAINING & CONTINUING EDUCATION**

**All clinical evaluators and treatment providers** listed on the registry are **required to attend either one or two day of training and orientation** sponsored by the department within six months of being placed on the registry. You will be notified of the next available training when your application is processed.

**All clinical evaluators and treatment providers** shall complete, every two years, **20 contact hours** of continuing education in **substance abuse** approved by the department. The department will not accept more than five hours of in-service training in each two-year period.

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**Part I PERSONAL  
INFORMATION**

*(Home address, home telephone number is confidential and will not be released under the Open Records Act, unless they are also your business address. Social security number is confidential)*

MUST BE COMPLETED INDIVIDUALLY  
BY  
ALL CLINICAL EVALUATOR APPLICANTS  
AND  
TREATMENT PROVIDER APPLICANTS WHO PROVIDE ONLY ASAM LEVEL I  
(Please Type or Print)

1. NAME: \_\_\_\_\_  
(Last) (First) (MI)
2. HOME ADDRESS: \_\_\_\_\_  
(City) (State) (Zip) (County)
3. HOME TELEPHONE NUMBER: \_\_\_\_\_
4. DATE OF BIRTH: \_\_\_\_\_ 5. Social Security Number: \_\_\_\_\_
6. OCCUPATION: \_\_\_\_\_  
(Main Source of Current Employment Income)
- EMPLOYED BY: \_\_\_\_\_

ATTACH ONE RECENT PHOTOGRAPH SHOWING A FULL VIEW OF THE FACE, NECK, SHOULDERS AND UNCOVERED HEAD. (SUCH AS A PASSPORT PHOTO) PHOTO COPIES NOT ACCEPTED.

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**Part II**  
**PROFESSIONAL CREDENTIALS**  
**REQUIRED BY ALL CLINICAL EVALUATOR APPLICANTS**  
**ALL TREATMENT PROVIDER APPLICANTS WHO ARE NOT LICENSED BY DHR'S OFFICE OF REGULATORY SERVICES**

1. List the licenses and/or credentials you presently hold: (Attach a photocopy of each Lic/Cred. Listed)

LICENSE/CREDENTIAL	LICENSE CREDENTIAL #	DATE RECEIVED	EXPIRATION DATE

2. Have any of the above Licenses/Credentials ever been suspended or revoked?

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**If yes, explain:** \_\_\_\_\_  
 \_\_\_\_\_

3. EDUCATION:

NAME OF COLLEGE	CITY/STATE	DATES ATTENDED MONTH/YEAR	MAJOR	DIPLOMA/DEGREE

4. I am applying to be listed in the registry as a (check as many as apply):

clinical evaluator

treatment provider

I am applying as a clinical evaluator ONLY, but I am also on staff at, or subcontract with, a treatment facility/practice.

NAME OF FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

(If you work for more than one treatment program, attach additional pages.)

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**PART III PROFESSIONAL PRACTICE**

Clinical Evaluator and ASAM Level I ONLY Treatment Provider  
(Note: Services may not be delivered in a private residence)

1. I will be providing the *clinical evaluator* services for multiple DUI offenders, as part of a: (check one)

Community Service Board  Private Treatment Facility   
Private Practice  Other Public Agency

If Private Practice or facility, please complete the following:

Sole Proprietorship  \* Corporation  \* Partnership   
For Profit  \* Non Profit

2. I will be providing Level I treatment only for Multiple DUI Offenders, as listed in the registry as part of a: (check one)

Private Practice  \* Public Agency  \* Private Treatment Facility

If Private Practice or facility, please complete the following:

Sole Proprietorship  \* Corporation  \* Partnership   
For Profit  \* Non Profit

**\* INFORMATION ABOUT PRACTICE \***

3. The Name of your Practice/Facility/Business (Main/Central Office)

Business Name:
Address:
City/State/Zip.
Mailing Address: (if different)
Business Telephone #( )                      2 <sup>nd</sup> Business #:( )
FAX Number: ( )
EMAIL Address (Mandatory)

4. Have you established a new practice in order to provide services as an approved clinical evaluator or treatment provider?  YES  NO

If no, how long has your practice been in existence? \_\_\_\_\_

5. Briefly describe your existing clientele and type of practice: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What percentage of your practice, if any, has been devoted to providing substance abuse services to DUI offenders or other criminal justice clients? \_\_\_\_\_

7. Does your practice/facility/business provide SA services in any languages other than English?

YES     NO

*If yes, list the other languages here:* \_\_\_\_\_

8. FOR ALL APPLICANTS: Have you had any experience in the last 5 years providing substance abuse evaluations and treatment to DUI offenders or other criminal justice clients?     YES     NO

*If yes, briefly describe this experience:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**PART IV**  
**SECTION I**  
**CLINICAL EVALUATOR APPLICANTS ONLY**

1. **DBHDD Rules require a face to face interview as part of the clinical evaluation**, and you are required to use the "Case Presentation Format" that is attached to this application for every client you evaluate. (Do not include DBHDD Case Presentation Format as part of this application, because it is already required). Include the following forms, formats and examples of your clinical evaluations to complete this part of the application process (*your application will not be reviewed beyond this section without the examples requested*).

a) Copy of your interview form, interview guidelines or format(s)

b) Copy of your last or most recent clinical evaluation done on a substance abuse client (with the identifying client information blacked out).

2. **In addition to your interview, do you use any independent screening instruments?**

YES     NO

List any screening instruments you may use in addition to the interview and explain the reason why you use them. (**Include a copy** of each instrument or a copy of the contract with the providing company, if copyrighted.)

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3. **Do you include a drug screen (urine test)?**     YES     NO  
If yes, include a copy of the laboratory's contract or the request form which is used.

4. **DBHDD Rules require that treatment recommendations be made according to ASAM Patient Placement Criteria.**

Have you *participated* in ASAM patient placement criteria training?     YES     NO

Are you familiar with the ASAM criteria?     YES     NO

Have you *used* the ASAM patient placement criteria?     YES     NO

5. **Do you have experience using the DSM IV Criteria for Substance Abuse, Substance Dependence and Substance-Induced Disorders?**     YES     NO

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If you are **ALSO** applying for your business/practice/facility to be on the registry as a **TREATMENT SITE** complete PART IV for **Treatment Providers**.

If you are applying as a Clinical Evaluator **ONLY**.....**PROCEED TO PART V**

INITIAL HERE \_\_\_\_\_

**PART IV  
SECTION II  
TREATMENT PROVIDER APPLICANTS ONLY**

1. List any individuals providing direct client care within your program under the supervision of the Clinical Supervisor:

<b>NAME</b>	<b>CURRENT CREDENTIALS</b>	<b>CREDENTIALS / CERTIFICATION SOUGHT</b>	<b>HOURS REQUIRED</b>

Clinical Supervisor: \_\_\_\_\_ Credentials: \_\_\_\_\_

Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

2. List any ongoing subcontractors who provide direct substance abuse client services through your program:

<b>NAME</b>	<b>ADDRESS</b>	<b>CITY</b>	<b>COUNTY</b>	<b>TELEPHONE #</b>

**DBHDD RULES REQUIRE THAT MANDATED TREATMENT FOR DUI OFFENDERS BE  
NO LESS THAN 3 HOURS PER WEEK, NO LESS THAN 120 DAYS AND NO MORE THAN 1 YEAR,  
FOR THE PURPOSE OF DRIVER'S LICENSE REINSTATEMENT**

**ATTACH THE FOLLOWING DOCUMENTS:**

1. Description of your program services.
2. Current fee schedules given to patient/clients.
3. Statement of confidentiality given to patient/clients.
4. Statement of patient/client rights given to patients/clients.
5. HIV antibody/AIDS status confidentiality given to patients/clients.
6. An anonymous patient/client sample record.

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PROCEED TO PART V**

**Initial Here \_\_\_\_\_**

**PART V.I CLINICAL  
EVALUATOR  
APPLICANT'S STATEMENT OF COMPLIANCE**

This is to certify that I am applying for approval to be included on the Department of Behavioral Health & Developmental Disabilities Registry of Clinical Evaluators and that all of the information contained on this application and the attached documents are true and correct. I have read the Rules and Regulations for Clinical Evaluation and Substance Abuse Treatment for DUI Offenders and understand that I am responsible for complying with all requirements.

**I FURTHER UNDERSTAND AND AGREE:**

In accordance with O.C.G.A. 16-10-20, to knowingly make a false statement or conceal a material fact in this application will result in the denial of my application or removal of my name from the Department's Registry.

**INITIALS** \_\_\_\_\_

I understand that I may only conduct clinical evaluations at the locations specified within my application and approved by the Department.

**INITIALS** \_\_\_\_\_

I understand that clinical evaluations may not be conducted in a private residence.

**INITIALS** \_\_\_\_\_

All client records shall be confidential and shall be maintained and disclosed in accordance with the provisions of Volume 42 of the Code of Federal Regulations, 42 Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records".

**INITIALS** \_\_\_\_\_

I understand that, as a Clinical Evaluator, I may not evaluate and treat the same client.

**INITIALS** \_\_\_\_\_

I understand that any and all fees for clinical evaluation must be within the range provided on my application and approved by the Department, and that I may not increase the fees for evaluation without prior notification to the Department. Upon approval of an increase in fee range, the new fee may not be charged until the next quarterly Registry Publication.

**INITIALS** \_\_\_\_\_

I agree to submit all reports and information to the Department as specified in the Rules and Regulations and maintain all client records, at the location specified on my application and provide access to the Department during the hours indicated on my application.

**INITIALS** \_\_\_\_\_

I understand that I must use the DBHDD "Case Presentation Format" for each client that I evaluate, or a substitute format officially approved by DBHDD.

**INITIALS** \_\_\_\_\_

I hereby authorize the release to DBHDD of any information necessary for the determination of my application for approval as a Clinical Evaluator. I understand that this information will be used only for the purpose of processing my application. Photocopies of this authorization will be valid for the purpose of obtaining requested information.

\_\_\_\_\_  
**APPLICANT'S SIGNATURE**

Sworn to before me this \_\_\_\_\_ day \_\_\_\_\_ 20\_\_\_\_\_

Notary \_\_\_\_\_ **(Seal Required)** \_\_\_\_\_

**PART V.2  
TREATMENT PROVIDER APPLICANT'S  
STATEMENT OF COMPLIANCE**

This is to certify that I/we are applying for approval to be included on the Department of Behavioral Health & Developmental Disabilities Registry of Treatment Providers and that all of the information contained on this application and the attached documents are true and correct. I/we have read the rules and Regulations for Treatment Provider and Substance Abuse Treatment for DUI Offenders and understand that I/we are responsible for complying with all requirements.

**I/WE FURTHER UNDERSTAND AND AGREE:**

In accordance with O.C.G.A. 16-10-20, to knowingly make a false statement or conceal a material fact in this application will result in the denial of my application or removal of the name from the Department's Registry.

**INITIALS** \_\_\_\_\_

I/we understand that I/we may only provide substance abuse services at the ASAM Levels of Treatment for which I/we have been approved for inclusion on the Registry and only at the locations specified within the application.

**INITIALS** \_\_\_\_\_

I/we understand that each substance abuse professional who provide services under this program must complete, every two years, a minimum of 20 contact hours of continuing education in the field of substance abuse approved by the department. Documentation of Said continuing education will be kept in staff personnel files.

**INITIALS** \_\_\_\_\_

All client records shall be confidential and shall be maintained and disclosed in accordance with the provisions of Volume 42 of the Code of Federal Regulations, 42 Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records."

**INITIALS** \_\_\_\_\_

I/we understand that, as a Treatment Provider, I/we may not evaluate and treat the same client.

**INITIALS** \_\_\_\_\_

I/we agree to submit all reports and information to the Department as specified in the Rules and Regulations and maintain all client records at the location specified on the application and provide access to the Department during the hours indicated on the application.

**INITIALS** \_\_\_\_\_

I/we hereby authorize the release to DBHDD of any information necessary for the determination of the application for approval as a Treatment Provider. I/we understand that this information will be used only for the purpose of processing the application. Photocopies of this authorization will be valid for the purpose of obtaining requested information.

\_\_\_\_\_  
**SIGNATURE OF PRINCIPAL OFFICER OF GOVERNING BODY**

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Notary

(Seal Require)

## **PART VI REGISTRY**

### **INFORMATION**

**If you are applying for both Clinical Evaluator and Treatment Provider, please complete both forms.**

**Provide the information exactly as you wish it to appear in the registry.**

**CLINICAL EVALUATOR INFORMATION CHANGE FORM**

<b>Section I - Registry Listing PRINT OR TYPE exactly as you want to appear on the registry Listing</b>		
New Provider: <input type="checkbox"/>	Existing Provider <input type="checkbox"/>	Date _____
UserID/Provider # _____		DBHDD USE ONLY
Change to Current Listing <input type="checkbox"/>	Add New Listing <input type="checkbox"/>	MHDDAD REGION: _____
Delete Listing <input type="checkbox"/>	ServiceID <input type="checkbox"/>	Provider No. For New Provider ____C____
First Name: _____	M. _____	Last Name: _____
Credential (Limit to three e.g. CACII, LPC, LCSW)		
Name of Facility /Practice/ Business (Where services are provided)		
Service Site		
Street Address:		
City: _____	County: _____	Zip Code: _____
Telephone No(s) to make an appointment (____)		(____)
(Minimum \$75) Fee Range: \$ _____ To: \$ _____		Sliding Scale: _____ Yes _____ No
Other Languages; (List Languages)		
Comments to appear on Registry: (Limit (to 100 spaces)		
<b>Section II - Mailing address and Private Contact Information (for Internal DHR Use only) Will not appear on the Registry.</b>		
Mailing Address:		
City: _____	State: _____	Zip Code: _____
Additional telephone # where we may reach you. Telephone No. (____)		Fax No. _____
Email Address:		
<b>Section III The following information is for DBHDD Use Only and will not appear on the Registry</b>		
Does your business share space with any other business? (Do not list other businesses in same shopping center or office complex) Yes_No_____		
If so, list name of business or institution:		
Type of business conducted:		
Contact Person: _____	Telephone No. (____)	
Location where DUI client files will be kept: ____ On Site ____ Other Location (Records May not be kept in a private residence.)		
If other location, Name of Facility where records are kept:		
Street Address:		
City; _____	County: _____	Zip Code: _____
Contact Person (for records): _____	Telephone No (for records): (____)	

**GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES**

For changes, **list your ID#, name and only** the information to be changed. Please make note of applicable deadlines when completing **this** form.

TREATMENT PROVIDER INFORMATION CHANGE FORM

<b>Section I - Registry Listing PRINT OR TYPE exactly as you want to appear on the registry Listing</b>			
Provider Type: TP      UserID/Provider # _____ _____ New Provider      Existing Provider: _____ Date: _____ _____ Add Listing _____ Change to Current Listing _____ Delete Listing      _____ Service Facility ID	DBHDD USE ONLY  MHDDAD REGION _____  Provider # T _____		
Name of Facility/Practice/Business (where services are provided)			
Service Site			
Street Address:			
City:	County:	Zip Code:	
Contact Person for appointments (if applicable):			
Telephone No(s) to make an appointment (    )		(    )	
Sliding Scale: _____ Yes _____ No			
Other Languages: (List Languages)			
Comments to appear on Registry: (Limit to 100 spaces)			
ASAM level (s) of Service: (Check or Circle all that apply)	Level I - (6 - 12 weeks) _____ Level I - (4 - 12 months) _____	ASAM Level II.1 or above II.1 II.5 III.3 III.5 III.7	ORS License #:
<b>Section II – Mailing address and Private Contact Information (for Internal DHR Use only) Will not appear on the Registry</b>			
Owner/Operator/Director: First Name:	MI:	Last Name:	
Credentials: (if applicable, limit list to three)			
Mailing Address:			
City:	State:	Zip Code:	
Additional telephone # where we may reach you. Telephone No. (    )		Fax No.	
Email Address:			
<b>Section III The following information is for DHR Use Only and will not appear on the Registry</b>			
Does your business share space with any other business? (Do no list other businesses in same shopping center or office complex) Yes _____ No _____			
If so, list name of business or institution:			
Type of business conducted:			
Contact Person:		Telephone No. (    )	
Location where DUI client files will be kept: _____ On Site      _____ Other Location (Records may <u>not</u> be kept in a private residence.			
If other location, Name of Facility where records are kept:			
Street Address:			
City:	County:	Zip Code:	
Contact Person (for records):		Telephone No (for records):	

For changes, list your ID#, name and only the information to be changed. Please make note of applicable deadlines when completing this form.

ADDENDUM A

SUBSTANCE ABUSE CONTINUING EDUCATION  
CONTACT HOURS

REQUIRED FOR ALL APPLICANTS WHO DO NOT HAVE THE  
SPECIFIC CREDENTIALS LISTED IN RULE 290-4-13.04(2)(a)-(f)

TWENTY (20) SUBSTANCE ABUSE SPECIFIC HOURS ARE REQUIRED  
NOT MORE THAN FIVE (5) IN-SERVICE HOURS MAY APPLY

*ALL 20 HOURS MUST HAVE BEEN EARNED DURING THE LAST TWO YEARS  
COUNTING BACK FROM THE DATE YOUR APPLICATION WAS NOTARIZED*

PLEASE DO NOT SEND CONTINUING EDUCATION HOURS THAT ARE MORE THAN TWO YEARS OLD  
THEY WILL NOT BE CONSIDERED

**PLEASE LIST ONLY THE 20 HOURS YOU ARE APPLYING  
&  
ATTACH CERTIFICATES, TRANSCRIPTS, OR SIGNED REPORTS AS VERIFICATION**

**YOU MAY REPRODUCE THIS PAGE IF NECESSARY TO LIST ALL 20 CONTACT HOURS  
(If you provide in excess of 20 hours, only the first 20 will be considered)**

1.	Title:	
	Provider:	Provider Number:
	Date(s):	Number of Contact Hours:
	<i>(1 CEU = 10 Contact Hours)</i>	

2.	Title:	
	Provider:	Provider Number:
	Date(s):	Number of Contact Hours:
	<i>(1 CEU = 10 Contact Hours)</i>	

3.	Title:	
	Provider:	Provider Number:
	Date(s):	Number of Contact Hours:
	<i>(1 CEU = 10 Contact Hours)</i>	

4.	Title:	
	Provider:	Provider Number:
	Date(s):	Number of Contact Hours:
	<i>{1 CEU = 10 Contact Hours}</i>	

5.	Title:	
	Provider:	Provider Number:
	Date(s):	Number of Contact Hours:
	<i>(1 CEU = 10 Contact Hours)</i>	

6.	Title:	
	Provider:	Provider Number:
	Date(s):	Number of Contact Hours:
	<i>(1 CEU = 10 Contact Hours)</i>	

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ADDENDUM B

EXPERIENCE VERIFICATION  
REQUIRED FOR ALL APPLICANTS WHO DO NOT HAVE THE SPECIFIC  
CREDENTIALS LISTED IN RULE 290-4-13.04(2)(a)-(f)

**CLINICAL EVALUATORS:** 2000 HOURS OF DIRECT SA CLIENT SERVICES  
INCLUDING NO LESS THAN 500 HOURS OF CLINICAL EVALUATION EXPERIENCE

**TREATMENT PROVIDERS:** 3000 HOURS OF DIRECT SA CLIENT SERVICES

**IF YOU ARE APPLYING FOR BOTH:** YOU MUST PROVIDE BOTH EXPERIENCE VERIFICATION  
FORMS

***YOU MAY MAKE AS MANY COPIES OF THE BLANK FORMS AS NECESSARY  
COMPLETED ORIGINALS MUST BE SENT DIRECTLY TO DBHDD, BY THE  
PERSON COMPLETING THE FORM***

***Only completed originals will be accepted***

**CLINICAL EVALUATOR  
VERIFICATION OF WORK EXPERIENCE  
( Print or Type)**

APPLICANT'S NAME: _____ <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>(First Name)</span> <span>(MI)</span> <span>(Last Name)</span> </div>
---

Name Of Person Verifying Applicant's Experience: \_\_\_\_\_  

(First Name)
(MI)
(Last Name)

Professional Credentials: \_\_\_\_\_

Location Of Work Experience You Are Verifying:(Facility)\_\_\_\_\_

(Street Address)\_\_\_\_\_

(City, County, State, Zip)\_\_\_\_\_

**Relation To Applicant During The Time Indicated: (check one):** Facility Administrator  
 Program Director  
 Supervisor

Colleague at same facility \_\_\_\_\_

Colleague at other facility \_\_\_\_\_

Other \_\_\_\_\_

**Dates Of Work Experience You Are Verifying: (From) Month \_\_\_\_ Year \_\_\_\_ (To) Month \_\_\_\_ Year \_\_\_\_**

**\*Average number of hours per week the applicant worked in substance abuse:**  
 [\* These are clients whose primary diagnoses is substance abuse/dependence or who are dual diagnosed)  
 (Direct Services: Client or Patient received individual or group counseling or therapy from the applicant)\_

<b>**Direct Services:</b> _____	<b>**Indirect Services:</b> _____	<b>Clinical Evaluation:</b> _____
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**Describe Indirect Services:**

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**I HEREBY VERIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND ACCURATELY REPRESENTS THE APPLICANT'S WORK EXPERIENCE IN THE FIELD OF SUBSTANCE ABUSE, AS I HAVE KNOWN IT.**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**PLEASE RETURN THIS FORM DIRECTLY  
 TO: Dept of Behavioral Health & Developmental Disabilities  
 Division of Addictive Disease  
 DUI Intervention Program Section  
 2 Peachtree Street, NW, 22<sup>nd</sup> Floor  
 Atlanta, Georgia 30303-3171**

**DO NOT RETURN THE ORIGINAL TO THE APPLICANT  
 TO DO SO WILL INVALIDATE THE INFORMATION  
 THANK YOU FOR YOUR TIME**

TREATMENT PROVIDER VERIFICATION  
OF WORK EXPERIENCE (PRINT OR  
TYPE)

APPLICANT'S NAME: \_\_\_\_\_  
(First Name) (MI) (Last Name)

Name of Person Verifying Applicant's Experience \_\_\_\_\_  
(First Name) (MI) Last Name

Professional Credentials: \_\_\_\_\_

Location of Work Experience You Are Verifying:

\_\_\_\_\_  
(Facility)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, County, State Zip),

Relation To Applicant During The Time Indicated: (Check One) Facility Administrator   
Program Director Supervisor   
Colleague at same facility   
Colleague at other facility   
Other

Dates of Work Experience You Are Verifying: {From} MTH \_\_\_\_\_ YR \_\_\_\_\_ {To} MTH \_\_\_\_\_ YR \_\_\_\_\_

\*Average number of hours per week the applicant worked in substance abuse: \_\_\_\_\_

*[\*These are clients whose primary diagnoses is substance abuse/dependence or who are dual diagnosed]*

*[Direct Services: Client or Patient received individual or group counseling or therapy from the applicant]*

Direct Services: \_\_\_\_\_

\*\*Indirect Services: \_\_\_\_\_

Describe Indirect Services:  
\_\_\_\_\_  
\_\_\_\_\_

I HEREBY VERIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND ACCURATELY REPRESENTS THE APPLICANT'S WORK EXPERIENCE IN THE FIELD OF SUBSTANCE ABUSE, AS I HAVE KNOWN IT.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE RETURN THIS FORM DIRECTLY TO:  
DBHDD, Division of Addictive Disease  
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