Registration Renewal Form

CADTP Registrants must renew annually and meet the renewal criteria. Renewal requires the following:

- ☐ Signed Uniform Code of Conduct; CADTP Code of Ethics with each page initialed;
- ☐ Three (3) hours of Ethics Continuing Education (CEU);
- ☐ Three (3) hours of Confidentiality Continuing Education (CEU);
- ☐ Proof of progress in the past 12 months towards certification - include one of the following:
  - ☐ 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 (unofficial) or 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, OR;
  - ☐ I have completed my educational requirements and have attached a letter from my employer to show I am working towards gaining the required work experience;
- ☐ Payment of $25 via check, money order or Visa/MasterCard;
- ☐ This renewal form completed, signed, and dated.

Your 5-year maximum Registration Date:		**You must renew your Registration by:**	

Name: Last	**First**		**Middle**
Full Street Address:	**City:**	**State:**	**Zip Code:**
Email Address (Required if you don't have one you can get one free from many providers online):			
Alcohol and/or Other Drug Counseling Employer – attach additional sheets if necessary. Write none if not currently employed			

Address:	**City/State/Zip**	**Telephone No.:**	**Date(s):** **From: _____ To: _____** **Month/Year**

Have you ever been denied, suspended, or revoked by the Department of Health Care Services (DHCS) or another certifying organization?
☐ **YES** ☐ **NO** **If yes, attach an additional page and provide details.**

By signing below, I am confirming all information is correct and that I have never been suspended or revoked by DHCS or 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 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): _____

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