Co-Occuring Disorder Specialist Enchancement Training Program Application Application Packet

Contents:

Important Information:

Mail your application and other documents to:

Co-Occurring Disorder Specialist Enhancement

Training Program

PO Box 47877

Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application Checklist and Instructions

When the department receives your application for approval as a Co-Occurring Disorder Specialist Enhancement Training Program it will be reviewed. You will be notified in writing of any outstanding documentation needed to complete the process.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Check One:**

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **1. Demographic Information:**

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Entity Name: List the legal name of the school, program or other entity.

Mailing Address: Enter the training program's complete mailing address.

Name of School or Program: Enter the name of the school or program as it appears on advertised signs, brochures, etc.

Physical Address: Enter the training program's complete physical address.

Mailing Address: Enter the training program's complete mailing address, if different from the physical address.

Phone and Fax Numbers: Enter the training program's phone and fax numbers.

Web Address: Enter the training program's web addresses, if applicable.

☐ **2. Contact Information:**

List the name, title, phone number and email address of the person that can be contacted about your application.

☐ **3. Applicant's Attestation:**

You must sign and date this for us to process the application.

address.

☐ **Required Supplemental Documents**

Please include documentation of training standards per RCW 18.205.105

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Washington State Department of Health

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Co-Occurring Disorder Specialist Enhancement Training Program Application

Check One

- ☐ Association
- ☐ Corporation
- ☐ Federal Government Agency
- ☐ Limited Liability Company
- ☐ Limited Liability Partnership
- ☐ Limited Partnership
- ☐ Municipality (City)
- ☐ Municipality (County)
- ☐ Non-Profit Corporation
- ☐ Partnership
- ☐ Sole Proprietor
- ☐ State Government Agency
- ☐ Tribal Government Agency
- ☐ Trust

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
Legal Owner/Operator Entity Name	
Mailing Address	

City	State	Zip Code	County
Name of School or Program			
Physical Address			
City	State	Zip Code	County
Mailing Address (if different from physical)			
City	State	Zip Code	County

Phone (enter 10 digit number)	Fax (enter 10 digit number)
Web Address	

2. Contact Information

Name	Title
Phone Number	Email Address

3. Signature

I, _____ representing _____

Name of Authorized Representative — Name of Program

attest that the training meets the training provider requirements outlined in RCW 18.205.105.

_____ _____

Signature of Authorized Representative — Date (mm/dd/yyyy)

RCW/WAC and Online Website Links

RCW Links

Co-Occurring Disorder Specialist Enhancement - Training Standards 18.205.105 RCW

Online

Web Page