Revenue 27030000

Mental Health Counselor Co-Occurring Disorder Enhancement Application

Applicant:
Use this Co-Occurring Disorder Enhancement for Mental Health Counselor working within approved agencies **RCW 18.205.105** and **WAC 246-804-030**. All information should be printed clearly in blue or black ink.

The enhancement may be added to your Washington State Mental Health Counselor License. To apply for the Co-Occurring Disorder Specialist Enhancement you must submit the following:

- Submit an application for Mental Health Counselor Co-Occurring Disorder Enhancement
- Submit fee according to **WAC 246-804-990**
- Completion of a 60-hour training course specifically relating to substance use treatment and approved by the department. Other training courses and college courses do not count toward the requirements. Official course completion or official transcripts must be submitted from the educational institution to the department
- Completion of the supervised experience requirement defined in **RCW 18.205.105(3)(c)**:
  - 80 hours of supervised experience for an applicant with fewer than five years of experience or;
  - 40 hours of supervised experience for an applicant with five of more years of experience

  Have your supervisor complete section three (3) of the enhancement application
- Successful completion of the **National Association of Alcoholism and Drug Abuse Counselors (NAADAC)** Level 1 or higher examination. If you have not already taken an approved exam, once we approve your education and supervised experience, we'll send you notification with instructions on registering for the exam
- The Co-Occurring Disorder Enhancement is valid with your active Washington Mental Health Counselor license in an approved practice setting.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Mental Health Counselor Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

Mental Health Counselor Co-Occurring Disorder Enhancement Application

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Print clearly:

Name Last	First	Middle

Birth Date (mm/dd/yyyy)	DOH Credential Number

Email Address

Address

City	State	Zip Code

2. Education

Provide a date order listing of graduate school(s) attended, major, month, and year the degree was granted. Request your transcripts from the graduate school(s) you attended, and have the graduate school send directly to the Department of Health.

Graduate School	Date Granted Month/Year	Degree and Major

3. Experience Verification RCW 18.205.105(5 and 6) (to be completed by your supervisor)

Experience Supervisor Name	Phone (enter 10 digit #)

Experience Supervisor License Number	License Expiration Date

Hours Verified

I attest that the above information is accurate and complete to the best of my knowledge.
I understand that the Department of Health may request additional information, if it is needed.

Supervisor's Original Signature _____ Date (mm/dd/yyyy) _____

4. Examination

Have you taken the **National Association of Alcoholism and Drug Abuse Counselors (NAADAC)** Level 1 or higher exam?

National Certified Addiction Counselor Level I (NCAC I) □Yes □No Month/Year_____

National Certified Addiction Counselor Level II (NCAC II) □Yes □No Month /Year_____

Master Addiction Counselor (MAC) □Yes □No □Yes □No Month /Year_____

5. Applicant Attestation

I,_____, declare under penalty of perjury under the laws of the state of
(Name of applicant)

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)