

Sacramento County

Department of Health Services

Division of Behavioral Health Services

AOD COUNSELOR APPLICATION

| Agency: | Date: |
|--|---|
| Contact Person: | Phone: |
| I attest that I, for the counselor classification category | , have the following qualifications required to register ory indicated below. |
| Certifying Organization. This of five (5) years from the date of r | An individual who is successfully registered in a DHCS Designated candidate must remain in good standing and complete certification within registration. On with a DHCS Designated Certifying Organization |
| exam issued by the DHCS De | individual who has completed program requirements and/or passed are signated Certifying Organization and is a "certified AOD Counselor" and AOD Counselor from a DHCS Designated Certifying Organization. |
| Applicant:Signature | · Date |
| Agency Representative: | ignature Date |
| BHS Quality Management: | ignature Date |

7001-A East Parkway, Suite 300 • Sacramento, California 95823 • phone (916) 875-0844 • fax (916) 875-0877 •