Sacramento County

Department of Health Services

Division of Behavioral Health Services

AOD COUNSELOR APPLICATION

Agency: _____ **Date:** _____.

Contact Person: _____ **Phone:** _____.

I attest that I, _____, have the following qualifications required to register for the counselor classification category indicated below.

☐ Registered AOD Counselor –An individual who is successfully registered in a DHCS Designated Certifying Organization. This candidate must remain in good standing and complete certification within five (5) years from the date of registration.
Must submit proof of registration with a DHCS Designated Certifying Organization

☐ Certified AOD Counselor. An individual who has completed program requirements and/or passed an exam issued by the DHCS Designated Certifying Organization and is a "certified AOD Counselor". Must submit proof as a Certified AOD Counselor from a DHCS Designated Certifying Organization.

Applicant: _____. _____.
Signature Date

Agency Representative: _____. _____.
Signature Date

BHS Quality Management: _____. _____.
Signature Date

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