STAFF AND HEALTH CARE PRACTITIONER (HCP) INFORMATION

INSTRUCTIONS FOR COMPLETION OF THIS FORM

Return completed form to the address below:

Licensing and Certification Division
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, California 95899-7413
Email: LCDQuestions@dhcs.ca.gov

DO NOT LEAVE any questions, boxes, lines, or fields blank. Enter N/A if not applicable to you.

For hard-copy submissions:
The form and all supportive documentation must be printed single sided, with 12-point font on 8 1/2" by 11" white paper.

DO NOT USE staples on this form or on any attachments.
DO NOT SUBMIT doubled sided or bound documents.
DO NOT USE plastic sheets or page protectors, correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.

PLEASE NOTE: Read all the instructions included on this form carefully and complete each item requested. For additional information regarding licensure of a residential alcoholism or drug abuse recovery or treatment facility providing alcoholism or drug abuse treatment or recovery services, please review Health and Safety Code section 11834.01 *et seq.* For additional information regarding the certification of an alcohol and other drug program providing alcohol and other drug (AOD) services, please review Health and Safety Code section 11832 *et seq.*. This form can be used for licensure of a residential alcoholism or drug abuse recovery or treatment facility and/or certification of an alcohol and other drug program. Accordingly, terminology applicable for licensure (including “resident” and “facility”) and terminology applicable for certification (including “client” and “program”) are both referenced within this form.

FACILITY/PROGRAM STAFFING DATA

This section must be completed by all applicants.

Facility/Program Name – Enter the name of the facility or program. Do not include the business entity name in this box unless the facility or program name is the same as the business entity name. Do not include the words or abbreviation for “Doing Business As,” unless you intend to use those words or the abbreviation in the facility or program’s name.

Total number of individuals currently employed or to be employed at this facility/program – Enter the total number of individuals, including staff, health care practitioners, and contractors.

Total number of alcohol and other drug (AOD) counselors and health care practitioners currently employed or to be employed at this facility or program – Enter the total number of registered or certified counselors and health care practitioners at this facility or program.

Total number of AOD counselors and health care practitioners currently employed or to be employed at this facility or program who provide alcoholism or drug abuse recovery or treatment services and/or AOD services – Enter the total number of AOD counselors and health care practitioners who provide alcoholism or drug abuse recovery or treatment services.

STAFF AND HCP INFORMATION

This section must be completed by all applicants.

List all staff and HCPs, (including contractors) who will provide alcoholism or drug abuse treatment or recovery services, and/or AOD services at this location. Use additional sheets as needed.

PLEASE NOTE: Pursuant to California Code of Regulations, Title 9, Section 10501 and Alcohol and Other Drug Certification Standards, the following terms are defined as follows:

"**Alcohol and Other Drug (AOD) Counselor**" means an individual registered or certified by a certifying organization in accordance with Chapter 8 (commencing with Section 13000), Division 4, Title 9 of the California Code of Regulations.

"**Health Care Practitioner (HCP)**" means a person duly licensed and regulated under Division 2 (commencing with Section 500) of the Business and Professions Code, who is acting within the scope of their license or certificate.

"Licensed Vocational Nurse" means a person licensed as a vocational nurse by the Board of Vocational Nursing and Psychiatric Technicians.

"Nurse Practitioner" means an advanced practice registered nurse who meets the Board of Registered Nursing's education and certification requirements, and who possesses the additional advanced practice educational preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary care, and/or acute care.

"Physician" means a person licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California.

"Physician Assistant" means a person licensed as a physician assistant by the Physician Assistant Board and that meets the requirements of Chapter 7.7 of Division 2 of the Business and Professions Code.

"Registered Nurse" means a person licensed as a registered nurse by the Board of Registered Nursing.

"**Staff**" means employees, interns, or volunteers at a facility or program, other than HCPs.

Facility/Program Name – Enter the name of the facility or program. Do not include the business entity name in this box unless the facility or program name is the same as the business entity name. Do not include the words or abbreviation for "Doing Business As," unless you intend to use those words or the abbreviation in the facility or program's name.

Facility License and/or Program Certification Number – Enter the facility license number or program certification number, if applicable.

Employee Information

Name – Enter the first and last name of the employee.

Title – Enter the title or role of the employee at the facility or program (i.e., program director, counselor, administrator, nurse practitioner, etc.).

Scheduled hours per week – Enter the employee's scheduled hours per week.

Contractor or Volunteer – Check the appropriate box to indicate if the employee is a contractor or a volunteer.

Date Hired – Enter the employee's hire date.

Date of Last TB Test – Enter the date of the employee's last TB test.

Date of Last First Aid Training – Enter the date of the employee's last First Aid training. Physicians, physician assistants, nurse practitioners, registered nurses, and licensed vocational nurses are not required to provide this date.

Date of Last CPR Training – Enter the date of the employee's last CPR training. Physicians, physician assistants, nurse practitioners, registered nurses, and licensed vocational nurses are not required to provide this date.

Licensed – Circle Yes or No as appropriate.

Certified – Circle Yes or No as appropriate.

Registered – Circle Yes or No as appropriate.

License/Certification/Registration Number – Enter the employee's license, registration, or certification number, as appropriate.

Issuing Organization – Enter the name of the organization that issues the license, certification, or registration, as appropriate. Issuing organizations include the following:

- Registered or certified counselor - Department approved certifying organizations;
- Physician - Medical Board of California or Osteopathic Medical Board of California;
- Psychologist - Board of Psychology;
- Nurse practitioner or registered nurse - California Board of Registered Nursing;
- Physician assistant - Physician Assistant Board;
- Licensed clinical social worker or a marriage and family therapist - California Board of Behavioral Sciences; or
- Intern - California Board of Behavioral Sciences or Board of Psychology.

Effective Date – Enter the effective date of the employee's license, certification, or registration, as applicable.

Expiration Date – Enter the expiration date of the employee's license, certification, or registration, as applicable.

DECLARATION

Print Name – Enter the first and last name of the individual signing the form.

Title – Enter the title of the individual signing the form.

Signature – Sign the form.

Date – Enter the date that the form is signed.

FACILITY/PROGRAM STAFFING DATA

Facility/Program Name:	
Total number of individuals currently employed or to be employed at this facility or program:	
Total number of alcohol and other drug (AOD) counselors and health care practitioners currently employed or to be employed at this facility or program:	
Total number of AOD counselors and health care practitioners currently employed or to be employed at this facility or program who provide alcoholism or drug abuse recovery or treatment services and/or AOD services:	

STAFF AND HCP INFORMATION

INSTRUCTIONS: Use this form to identify all staff and HCPs at the facility or program. Use additional sheets as needed.

Facility/Program Name:	**Facility License and/or Program Certification Number:**
Counselor Information:	

Employee Information	**Date Hired**	**Date of Last TB Test**	**Date of Last First Aid Training***	**Date of Last CPR Training****	**Licensed**	**Certified**	**Registered**	**License/ Certification/ Registration**
Name:					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Number:
Title:								Issuing Organization:
Scheduled hours per week:								Effective Date:
☐ Contractor ☐ Volunteer								Expiration Date:
Name:					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Number:
Title:								Issuing Organization:
Scheduled hours per week:								Effective Date:
☐ Contractor ☐ Volunteer								Expiration Date:

Facility/Program Name:	**Facility License and/or Program Certification Number:**
Counselor Information:	

Employee Information	**Date Hired**	**Date of Last TB Test**	**Date of Last First Aid Training***	**Date of Last CPR Training****	**Licensed**	**Certified**	**Registered**	**License/ Certification/ Registration**
Name:					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Number:
Title:								Issuing Organization:
Scheduled hours per week:								Effective Date:
☐ Contractor ☐ Volunteer								Expiration Date:
Name:					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Number:
Title:								Issuing Organization:
Scheduled hours per week:								Effective Date:
☐ Contractor ☐ Volunteer								Expiration Date:

Facility/Program Name:	**Facility License and/or Program Certification Number:**
Counselor Information:	

Employee Information	**Date Hired**	**Date of Last TB Test**	**Date of Last First Aid Training***	**Date of Last CPR Training****	**Licensed**	**Certified**	**Registered**	**License/ Certification/ Registration**
Name:					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Number:
Title:								Issuing Organization:
Scheduled hours per week:								Effective Date:
☐ Contractor ☐ Volunteer								Expiration Date:
Name:					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Number:
Title:								Issuing Organization:
Scheduled hours per week:								Effective Date:
☐ Contractor ☐ Volunteer								Expiration Date:

Facility/Program Name:	**Facility License and/or Program Certification Number:**
Counselor Information:	

Employee Information	**Date Hired**	**Date of Last TB Test**	**Date of Last First Aid Training***	**Date of Last CPR Training****	**Licensed**	**Certified**	**Registered**	**License/ Certification/ Registration**
Name:					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Number:
Title:								Issuing Organization:
Scheduled hours per week:								Effective Date:
☐ Contractor ☐ Volunteer								Expiration Date:

***** Physicians, physician assistants, nurse practitioners, registered nurses, and licensed vocational nurses are not required to provide this date.

** Physicians, physician assistants, nurse practitioners, registered nurses, and licensed vocational nurses are not required to provide this date.

DECLARATION	
I declare under penalty of perjury under the laws of the State of California that the foregoing information and any attachment is true, accurate and complete to the best of my knowledge and belief. I hereby further declare that I will comply with the statutes, regulations and standards that govern the operation of this facility or program. I declare that I am authorized to sign this form.	
Print Name:	Title:
Signature:	Date:

PRIVACY NOTICE ON COLLECTION

The purpose of this form is to collect information for licensure or certification of residential alcoholism and drug abuse recovery or treatment facilities or treatment program. The information collected in this form is required by the Department of Health Care Services (Department), Licensing and Certification Division, Licensing and Certification Section by the authority of Health and Safety Code, Section 11834.01 et seq. and California Code of Regulations, Title 9, Division 4, Chapter 5 and the Alcohol and Other Drug Program Certification Standards 2.0. The personal information collected in this form is confidential and protected by the Information Practices Act (California Civil Code 1798, et seq.), Department policy, and state policy.

All information requested in this form is mandatory. The consequence of not supplying the mandatory information requested or supplying incomplete information is that review of the application shall be terminated. The Department may share provided information with other state agencies to perform its constitutional or statutory duties where the use is compatible with a purpose for which the information was collected. The Department may also share information with local, state, or federal government entities if required by state or federal law. Please do not provide any personal information other than the information that is specifically requested in this form.

In most cases, individuals have a right to access information about them that is in federal and state records. For more information or access to records containing your personal information maintained by the Department, contact the following:

Licensing and Certification Division
Section Officer of the Day
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, California 95899-7413
Tel: (916) 322-2911

The Department of Health Care Services' policies regarding personal information are available online in the Department's Notice of Privacy Practices (https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).