

# Certified Substance Abuse Program Administrator Candidate Application

## *PERSONAL INFORMATION*

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**Name:** \_\_\_\_\_  
Last First Middle

**Former Name:** \_\_\_\_\_  
(if applicable) Last First Middle

**Company:** \_\_\_\_\_  
Name

**Address:** \_\_\_\_\_  
Number & Street

**Address 2:** \_\_\_\_\_  
Number & Street

\_\_\_\_\_  
City State Zip Code

**Business Phone #:** ( ) \_\_\_\_\_ **Fax #:** ( ) \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

## *EXPERIENCE*

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How many years of full-time experience do you have as a substance abuse program administrator? \_\_\_\_\_

Please check the blocks below indicating the areas in which you have experience.

- |  |  |
|--|--|
| <input type="checkbox"/> Compliance with applicable federal and state laws           | <input type="checkbox"/> Development of drug-free workplace policies and procedures                          |
| <input type="checkbox"/> Administration of drug and alcohol testing programs         | <input type="checkbox"/> Performance or supervision of specimen collection and/or alcohol testing procedures |
| <input type="checkbox"/> Medical Review Officer (MRO) interaction/supervision        | <input type="checkbox"/> Substance Abuse Professional (SAP) interaction/supervision                          |
| <input type="checkbox"/> Preparation and/or delivery of drug-free workplace training |  |

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## *TRAINING*

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Complete the following (a minimum of 40 hours is required). Please attach supporting documentation for each course, ie a course description and/or proof of attendance. A maximum of 8 hours is allowed per course.

<u>Date(s)</u>	<u>Course Name</u>	<u>Sponsor</u>	<u>Hours</u>
_____	_____	_____	_____
_____	_____	_____	_____
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## *EXAMINATION*

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**Exam Date and Location –**

Please record the examination date and location you desire to attend.

\_\_\_\_\_

**Special Examination Arrangements –**

Please check the box to the right should you require special accommodations due to a disability. Attach documentation as described in the SAPACC Information Guide.

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## ***CANDIDATE STATEMENT***

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By submitting this application I acknowledge, understand and agree to all the provisions contained in the application and the SAPACC Information Guide. I attest that the foregoing information is accurate and true and that I meet the requirements for this examination and / or renewal of my C-SAPA certification as stated on the application and in the SAPACC Information Guide. I agree that in the event my examination papers are lost, or if the examination is not held for any reason, any claim that I may have will be limited to the fee paid by me to SAPACC. I understand and agree to the refund policy as stated. In addition, I understand that my certification if attained, or when renewing this certification, depends on my adherence to the Commission's published practice standards for which I have applied. I further understand and agree that my name may be used for publication in professional literature and marketing materials upon attaining a C-SAPA certification.

Printed Name Preferred on Certificate: \_\_\_\_\_

\_\_\_\_\_  
Signature Date

**Submit the application, fee and any required supporting documentation to:**

SAPACC  
7220 SW SYLVAN CT  
PORTLAND OR 97225-3742  
Telephone 866.538.4788 Fax 503.297.4748  
**E-mail: stopdrugs@aol.com**