

California Association for Alcohol/Drug Educators

5230 Clark Ave., Suite 1, Lakewood, CA 90712
Phone: 707-722-2331 • Email: office@caade.org
Fax: 562-275-3494 • www.caade.org

Institutional/Organizational Membership

CAADE offers a group Membership rate to Institutions and Organizations. This includes but is not limited to: Colleges, Universities, Treatment Centers, and Alcohol & Other Drugs Facilities.

Institutional Memberships include a membership or registration card for each individual and a *Certificate of Membership* for your Institution or Organization as well as a link on caade.org. Each individual to be included must complete a separate page of this application.

If you pay by credit card or PayPal online at caade.org, please include a copy of your receipt. Checks and money orders may be made payable to CAADE, please include with this application.

Institution/Organization: _____

Address: _____

City, State, Zip: _____

Contact Person: _____

Contact Phone: _____

Contact Email: _____

Full Name of each person receiving Membership or Registration (include additional pages if needed):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____ 11. _____ 12. _____

Please submit the following for each registrant/member:

- Code of Ethics** – Initial, Signed and Dated
- Scope of Practice** – Signed and Dated
- Code of Conduct** – Signed and Dated

IMPORTANT NOTE FOR REGISTRANTS: The State of California’s Department of Health Care Services REQUIRES you to become certified within FIVE [5] YEARS from the first date you register with any approved certifying organization in California. You may request a two-year extension for hardship or extenuating circumstances. You may not be “registered” once you have passed the five-year limit unless you are granted an extension.

Each individual must complete a separate form

Please check ONE statement below that applies to you:

_____ It is my intention to be registered for the purpose of becoming certified with CAADE as a Certified Addictions Treatment Counselor (CATC) in compliance with Title 9, Division 4, Chapter §13035(f) of the California Code of Regulations for Alcohol and Drug Counselor Certification.

Registration is open to individuals who **have completed, or are enrolled in, a CAADE accredited Alcohol/Drug Studies Program and have NOT yet passed the CATC exam.*

***Please attach proof of education or enrollment in a CAADE accredited program.**

***If you are registering but are NOT in school, you must attach proof of completion of 9 hours of Laws and Ethics before your registration can be processed.**

Have you ever been registered with another certifying organization in California? _____

No

Yes

Have you ever held certification that is suspended/revoked? ___ Yes ___ No

If Yes, name of organization: _____ Date registered: _____
(CAADAC, Breining, CAARR, CADTP, AAHCP, CCAPP)

_____ I am a CATC and need to renew my CAADE Membership.

CATC# _____ Date of Expiration: _____

_____ It is my desire to become a CAADE member, but I do **not** plan on becoming certified as a CATC

Full Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____

Email: _____

Last 4 of SSN: _____

DOB: _____/_____/_____

(For Identification Purposes Only)

M M D D Y Y

CAADE College of Attendance: _____

I have read and agree to abide by the CAADE Code of Ethics/Code of Conduct/Scope of Practice. It is my understanding that I am to uphold all 11 principles in my work and in all contact with clients/patients, either employed or volunteering, and by signing this application, I agree to abide by these ethical standards. I understand that my Registration or Membership and Certification can be revoked if I violate any of these ethical standards.

Signature of Applicant

Date Signed

Each individual must complete a separate form

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Have you ever been registered with another certifying organization in California? No Yes

If Yes, name of organization: _____ Date registered: _____
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CATC# _____ Date of Expiration: _____

_____ It is my desire to become a CAADE member, but I do **not** plan on becoming certified as a CATC

Full Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____

Email: _____

Last 4 of SSN: _____

DOB: ____/____/____

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No

Yes

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CATC# _____ Date of Expiration: _____

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Full Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____

Email: _____

Last 4 of SSN: _____

DOB: ____/____/____

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CATC# _____ Date of Expiration: _____

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Full Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____

Email: _____

Last 4 of SSN: _____

DOB: ____/____/____

(For Identification Purposes Only)

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CATC# _____ Date of Expiration: _____

_____ It is my desire to become a CAADE member, but I do **not** plan on becoming certified as a CATC

Full Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Email: _____

Last 4 of SSN: _____ DOB: _____/_____/_____

(For Identification Purposes Only) M M D D Y Y

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