***COMPULSIVE GAMBLING TRAINING APPLICATION ***

[Please print or type]

APPLICANT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

_____ E-Mail: _____

City/State/Zip: _____ County: _____

EMPLOYMENT INFORMATION

Job Title: _____

Employer: _____

Street Address: _____

City/State/Zip: _____ Work Phone: _____

Work Setting: ☐ CD Residential Services ☐ Outpatient CD ☐ Outpatient MH

☐ Methadone Maintenance ☐ Prevention ☐ Other specify:_____

PROFESSIONAL INFORMATION (*check highest level of education and attach supporting documentation):*

Education: ☐ GED ☐ High School ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Doctoral or higher

Current Credentials or Licenses (*check all that currently apply to you and submit supporting documentation*):

☐ CASAC ☐ Occupational Therapist ☐ Psychologist ☐ NBCC Cert. Counselor

☐ CPP/CPS ☐ Physician ☐ Rehabilitation Counselor

☐ LCSW/LMSW ☐ Physician's Assistant ☐ Therapeutic Recreation Specialist

☐ Nurse Practitioner ☐ Professional Nurse ☐ Family Therapist

List Experience in Gambling Treatment and/or Prevention: _____

_____

I am interested in the: ☐ 60-hour Treatment Core Curriculum ☐ 30-hour Prevention Core Curriculum

ATTESTATION

I agree to apply the knowledge gained from this OASAS-supported training program to: (1) pursue acquisition of a compulsive gambling credential or specialty designation; and/or (2) provide targeted compulsive gambling services in a treatment and/or prevention setting.

_____	_____	_____
Print Name	Signature	Date

Please complete and return Application to:

NYS OASAS
ATTN: Training/Technical Assistance Unit
1450 Western Avenue
Albany, NY 12203-3526