OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
Division of Healthcare Professionals

BOARD OF LICENSING FOR ALCOHOL & OTHER DRUG USE PROFESSIONALS
CRSW

APPLICATION FOR REINSTATEMENT

NAME:_____

ADDRESS:_____

_____

TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

CERTIFICATE NUMBER: _____

EXPIRATION DATE: _____

TODAY'S DATE: _____

Estimated time of lapse (not to exceed 5 years)_____

Reinstatement fee $100 per each lapsed year (rounded up to the nearest full year) in addition to the recertification fee of $110.

****PLEASE NOTE: YOU NEED TO PROVIDE DOCUMENTATION OF 12 HOURS OF EDUCATION AND TRAINING REQUIRED FOR RECERTIFICATION PLUS AN ADDITIONAL .5 HOURS FOR EACH MONTH THAT YOUR CERTIFICATE HAS BEEN LAPSED. ****