Texas Department of State Health Services

Drug Offender Education Program

Administrator/Instructor Training Application

---PLEASE DO NOT SEND MONEY WITH THIS APPLICATION---

Applicant Information

All information is required ■ Do not leave questions blank, use N/A if not applicable

Please Print Clearly or Type

Mr. Ms. (please circle) Name:		
Home Mailing Address:		
City:	ZIP:	County:
Home Phone: ( )	Work Phone: ( )	
Fax: ( )	Social Security Number:	
Cell Phone: ( )	Drivers License Number:	
Email address:	Date of Birth:	

Current Employment Information

Current Employer (Agency/Organization):
Title:
Position Description:

Licenses (Check all that apply)

Counselor Intern (LCDC or LPC)-circle	☐Yes ☐No	Licensed Psychiatrist/Physician	☐Yes ☐No
Licensed Chemical Dependency Counselor	☐Yes ☐No	Probation or Parole Officer	☐ Yes☐No
Licensed Social Worker	☐Yes ☐No	Adult or Child Protective Services Worker	☐Yes ☐No
Licensed Professional Counselor	☐Yes ☐No	Licensed Vocational Nurse	☐Yes ☐No
Licensed Psychologist	☐Yes ☐No	Registered Nurse	☐Yes ☐No
Certified Teacher	☐Yes ☐No		

Certifications (Check all that apply)

DSHS – DWI Education (DWIE) Instructor	☐ Yes	☐ No
DSHS - Alcohol Education Program for Minors (AEPM) Instructor	☐ Yes	☐ No
DSHS - DWI Intervention (DWII) Instructor	☐ Yes	☐ No
DSHS – Texas Youth Tobacco Awareness Program (TYTAP) Instructor	☐ Yes	☐ No
Other Certifications—please list:		

Case Management/Clinical Counseling/Teaching Experience

Specify Type of Clinical Counseling or Case Management Experience	Number of Years	Specify Type of Teaching Experience	Number of Years

Educational Background

Name of College/University	Type Degree Awarded	Major	Minor	Dates Attended

For Office Use Only	
Reviewed By:	*Date:*
Approved: ☐*Yes* ☐ *No*	
If not approved, why:	

Describe, in detail, your case management/clinical counseling/educational experience relating to substance abuse or mental health: **(Include agency names & dates)**

ALL INSTRUCTORS MUST TEACH FOR CERTIFIED PROGRAMS

Please choose one:

1. I expect to be employed as an (check one) ☐ Administrator/Instructor or ☐ Instructor for the Texas Drug Offender Education Program, with:

Name of DOEP Program:

Program Number:

Program Mailing Address: City ZIP

Program Phone Number:

*If you will be teaching for a program that is already established, this portion **MUST BE** completed by the program administrator of that program, who is authorizing your workshop attendance.*

I, , HEREBY AUTHORIZE

TO ATTEND THE DRUG OFFENDER EDUCATION PROGRAM ADMINISTRATOR/INSTRUCTOR TRAINING.

THE APPLICANT I AM RECOMMENDING AND AUTHORIZING TO ATTEND THIS WORKSHOP

MEETS THE REQUIRED QUALIFICATIONS.

_____

DOEP Program Administrator Signature

-OR-

2. I will submit an application for certification of a new Texas Drug Offender Education Program. ☐ Yes ☐ No
(additional expenses involved)

I certify that all information contained in this application and attachments is true and correct.

Signature of Applicant: _____ **Date:** _____

RETURN THE COMPLETED APPLICATION, CURRENT RESUME, AND PROOF OF CREDENTIALS (copies of diplomas and/or licenses) TO:

Texas Department of State Health Services
PLCU - Offender Education
PO Box 149347, Mail Code 1982
Austin, TX 78714-9347

Incomplete applications or applications without appropriate attachments will not be processed.

---- DO NOT SEND MONEY WITH THIS APPLICATION ----

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