APPLICATION FOR APPROVED PROVIDER STATUS

NORTH DAKOTA BOARD OF ADDICTION COUNSELING EXAMINERS
PO BOX 975
BISMARCK, ND 58502-0975
PHONE 701-255-1439
FAX 701-224-9824
E-MAIL: ndbace@aptnd.com
www.ndbace.org

Please Type or Print Clearly.

Identification:

Provider Name:____

Address:____
____
____

Phone: ________________________ **E-mail:**_________________________

Describe Qualifications:____
____
____
____
____

I/We hereby apply for approved provider status for continuing education. I/We hereby attest that I/We have received a copy of the guidelines and criteria regarding continuing education and agree to present programs that meet the North Dakota Board of Addiction Counseling Examiner's criteria governing continuing education for addiction counselors.

_________________________ _________________________
Administrator Continuing Education Coordinator

Date: ___________________________

****Please return completed form with $100 fee to above address.**

DO NOT WRITE BELOW THIS LINE

_____________________________________[ ] has/ [ ] has not been granted an "Approved Provider" status for continuing education by the North Dakota Board of Addiction Counseling Examiners, effective ______________________________ to ______________________________.

Provider number: ____________________

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Continuing Education Monitor

2/08