PROVIDER APPLICATION FOR RECOGNIZED CLOCK HOURS (RCH) ENDORSEMENT

Ohio Chemical Dependency Professionals Board
77 S. High Street, 16th Floor ♦ Columbus, OH 43215
614-387-1110 phone 614-387-1109 fax www.ocdp.ohio.gov

An organization that has sponsored 50 hours of Board approved education may apply to become an RCH Provider. Provider status gives the organization a Provider Number (PVN) to use on all programs that are applicable to the field of chemical dependency counseling and prevention. Organizations can apply for a one or two year Provider Number. Once approved, it is the organizations responsibility to use their approval number and assign letter designations to their educational events. In addition, each provider must submit a quarterly report to the Board which details the educational events they have been conducting.

Providers may advertise that their trainings have board approval in the form of RCHs. Providers are required to provide a certificate of attendance to each participant indicating completion of the training. The attendance verification must show the provider's name, the date of the training, the number of RCHs awarded, the PVN #, letter classification and the name of the participant. Certificates must be signed by an individual administering the program.

The Board credentials chemical dependency counselors, clinical supervisors and prevention specialists. Board approved providers assign each educational event a letter classification to indicate the appropriateness of the event for each credential. They are as follows:
C = CD specific S = clinical supervisory P = prevention D = diagnostic R = field related

This classification is placed behind the PVN# and can be any combination of approvals (ex. 04-0406-12PVN CS, 02-0306-04PVN P, etc).

Please type or print all information and return to the Board.

I. CONTACT INFORMATION

Program Sponsor: _____

Agency/Institution/Business

Contact Person: _____

Name Title

Address: _____

_____

City State Zip Code

Telephone #: _____ **Fax #:** _____

Email Address: _____

Our organization would like to apply for a:

_____ **One year provider status ($400.00)** _____ **Two year provider status ($700.00)**

II. PROGRAM INFORMATION

Please list, at a minimum, fifty (50) hours of education for which your organization was awarded RCHs by the Board. Each listing should include the title of the educational event, the date(s) the event was held, the Program Identification # (PID#) awarded by the Board and the number of RCHs approved.

This page may be duplicated as needed to document the total number of required hours.

TITLE OF COURSE/EVENT	DATE(S)	PID #	# RCHs

III. PROVIDER AGREEMENT

Upon approval of my Provider Application, I agree to abide by all of the following terms set forth by the Board. I understand that the Board reserves the right to request additional information and may deny the request for provider status if it is not deemed appropriate or acceptable. I understand that, upon approval, my provider status date will be the first day of the month my application is received by the Board and will run until the first day of the month at the end of my one or two year provider status. I further understand that I may renew my provider status when I reach the end of my one or two year provider period.

- **I agree to plan educational events that will benefit chemical dependency counselors and prevention specialists and will ensure that these events cover content areas required by the Board. I further agree that I will not use my provider number on educational events that do not meet Board criteria.**

- **I agree to withdraw the approval number for any educational event the Board indicates does not meet the content area requirements.**

- **I agree to accept all responsibility for verification of attendance at each of our educational events. I will provide certificates of attendance to individuals that verify the provider name, the date of the training, the number of RCHs awarded, the PVN# and the name of the participant. I agree to determine the letter classification for each respective event and place all letters at the end of the provider number for each program. I agree to award hours based on actual educational time. I will subtract breaks and introductory speakers from the total hours awarded.**

- **I agree to keep attendance rosters of each educational event for five years.**

- **I agree that I will not charge additional fees for individuals to receive RCH credit or certificates.**

- **I agree to submit quarterly reports to the Board along with all information requested for these reports.**

- **I agree to open my educational events, at no charge, to the Board or a Board designated individual to allow them to monitor an event. I further agree to cooperate with the Board should an official monitoring be required.**

- **I agree that I will us my provider number only for educational events presented during my approved provider status. I further agree that I will not use my provider number once my provider status has expired.**

I understand that my provider status may be revoked due to falsification of forms, failure to remain in compliance with the Board's approved criteria and policies, investigation and verification by the Board of written complaints or charges by consumers or others and refusal to comply with an investigation by the Board. If my provider status is revoked, I agree to cease using my provider number and remove it from publicity material and certificates of attendance distributed after the effective date of the revocation. I further understand that my provider application fee is a non-refundable fee.

_____ _____

Signature **Date**

OFFICE USE ONLY

Date received _____ **Fee enclosed** _____ **Check/MO/CC#** _____

_____ **Approved** _____ **Deficient** _____ **Denied**

Comments:_____

Reviewed By: _____ _____

Signature Date

Last Updated 06/10

PROVIDER APPLICATION CHECKLIST

The following is a checklist to assist in the preparation of applications for approval of RCH Provider Applications. Please make sure that each of the following are completed prior to submitting your application.

_____ Application complete including:

_____ Fifty (50) hours of Board approved training

_____ Agreement statement has been read and signed

_____ Fee enclosed, made payable to *Treasurer, State of Ohio*.

For any questions regarding the completion of this application, please contact the Board office at (614) 387-1110.

Credit Card Payment Authorization Form

Please check one: ☐ Master Card ☐ Visa

Cardholder Name: _____

Address: _____

City, State, Zip: _____

Telephone #: _____

Email Address (for receipt) _____

Credit Card Number: _____

Expiration Date: _____

CVV2/CID Code # (Three digit number on back of card): _____

Payment Amount: _____

Payment for (exam, application, etc): _____

_____ _____

Signature Date

Credit Card Payments may be mailed, faxed, emailed, or phoned in to the Board office.

Ohio Chemical Dependency Professionals Board
77 South High Street, 16th Floor Columbus, Ohio 43215
614/387-1110 (phone) 614/387-1109 (fax) www.ocdp.ohio.gov
Email: credentialing@ocdp.state.oh.us

This document will be shredded after your payment is processed.