



FOR OFFICE USE ONLY

Date Received

ID #

Issue Date

License #

**Rhode Island
Department of Health
Office of HIV/AIDS and Viral Hepatitis**

Room 106
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

Certification As A

Qualified Professional Test Counselor

DO NOT REMOVE THIS PAGE FROM APPLICATION

Applicant - Print Name (First, MI, Last)

Phone: (401) 222-2320

TTY/TDD: (800) 745-5555

Fax: (401) 222-2488

Revised 09/23/2011 jcp

GENERAL INFORMATION

Qualified Professional Test Counselor Applicants

- Completed and Signed Application
- Documentation of successful completion of a Department approved Qualified Professional Test Counselor training course.

Rules and Regulations/Laws

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

<http://www.health.ri.gov/atoz/>

Chapter 23, Title 6.3 entitled "Prevention and Suppression of Contagious Diseases - HIV/AIDS" can be downloaded at the following web site:

Initial Certification <http://www.rilin.state.ri.us/Statutes/TITLE23/23-6.3/INDEX.HTM>

Once your completed application has been reviewed and approved, you will be issued your certificate. Certificates shall be issued for a period no longer than two (2) years and shall expire on the last day of the month (two) 2 years from the date of issue.

Renewals

A renewal notice will be mailed to you approximately sixty (60) days prior to the certification expiration date. For renewal of this certification you will need to document successful completion of at least six (6) contact hours within the twenty-four month term of your current certification. You will also need to attend a Department-approved counseling skills assessment session within the twenty-four (24) month term of your current certification.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.

Mail completed application and documents to:

**Rhode Island Department of Health
Office of HIV/AIDS and Viral Hepatitis
Room 106, 3 Capitol Hill
Providence, RI 02908-5097**

Once applications are reviewed and approved a certificate will be mailed. You are responsible for notifying the Office of HIV/AIDS and Viral Hepatitis, in writing, of any changes of address.

To obtain your license number prior to receiving your certificate, please refer to the HEALTH Licensee Lookup web site:

<https://healthri.mylicense.com/Verification>

Applicant: Print your complete last name >

7. Preferred Mailing Address

Please check ONE

Please use my Home Address as my preferred mailing address

Please use my Business Address as my preferred mailing address

8. Training Information

Date Qualifying Professional Test Counselor Practicum was Taken:

Month Day Year

9. Disciplinary Questions

Check either Yes or No for each question.

- 1. Have you ever been sanctioned by any Department of Health Licensing Board?
2. Have you ever been declared mentally incompetent by any court?
3. Have you ever been convicted of a felony violation of any state or federal law?
4. Have you been impaired by any controlled substance or any alcoholic beverage to the extent that the use impairs your ability to practice the HIV test counseling skill that is authorized by this certification?

NOTE: If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter.

If necessary, you may continue on a separate 8 1/2 x 11 sheet of paper.

10. Affidavit of Applicant

Please read and sign this section.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct.

I further declare that I have filed all required state tax returns and have either paid all taxes due the state or entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Office of HIV/AIDS of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)