OTPG Opioid Treatment Providers of Georgia

supported by **CareLink of Georgia**

MOUD/WDT Application

Personal Information

Full Name: _____   **Date of Birth:** _____

Address: _____

Email: _____   **Daytime Phone:** _____

Preferred Pronouns (optional) _____

Employment Information

Name of Business (or Institution) _____

Present Occupation _____

Date of Hire (Month/Year) _____

Are you a Member of OTPG?   Yes   How Long?   No

Certified and working in the field?   Yes   How Long?   No

Certified and <u>not</u> working in the field?   Yes   How Long?   No

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Optional Information that can be submitted: Proof of the following certifications.

GACA, ADACBGA, NBCC, etc.)

Attachments: Proof Of Certification Provided

Declaration:

By submitting this application, I confirm that the information provided is accurate, and I understand that any false statements may disqualify me from this scholarship.

Signature   **Date**