

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**FAX #:** (608) 261-7083  
**Phone #:** (608) 266-2112

**Ship To:** 1400 E. Washington Avenue  
Madison, WI 53703  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.wi.gov>

**DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING**  
**CERTIFICATE OF COMPLETION OF A DEPARTMENT-APPROVED**  
**SUBSTANCE USE EDUCATION PROGRAM**

**APPLICANT: COMPLETE TOP PORTION OF THIS FORM AND FORWARD TO THE SCHOOL IN WHICH YOU COMPLETED THE SUBSTANCE ABUSE PROGRAM.**

**Please check a box:**  SAC-IT  SAC  CSAC

Last Name  First Name  MI  Former/Maiden Name(s)

Address (street, city, state, zip)

Date of Birth  /  /  Social Security # (Voluntary-For use by school to locate your records)  -  -

I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature  Date  /  /

**SCHOOL: COMPLETE SECTION BELOW AND RETURN DIRECTLY TO DSPS. YOU MAY FAX/EMAIL WITH FACILITY COVER SHEET/LETTER TO: (608) 261-7083 or [dspscredsubstanceabuse@wisconsin.gov](mailto:dspscredsubstanceabuse@wisconsin.gov).**

Name of School and Degree/Certificate/Program

**The above named applicant has graduated from or completed:** (please check a box below)

**SAC-IT**

100 hours of a Department-approved education program in the performance domains of assessment, counseling, case management, patient education and professional responsibility (Wis. Admin. Code § SPS 161.01(4)).

**SAC/CSAC**

360 hours of a substance use disorder Department-approved program (Wis. Admin. Code §§ SPS 161.02(4) and 161.03(4)(b)).

**Date of Graduation or Completion:**  /  /

**Was this program approved at the time of graduation or completion?**  Yes  No

Signed  Date  /  /

Title