



Initial Application – Service Hours

Service Hours Focused On Tobacco Dependence Treatment As Part of Direct Patient/Client Care

Instructions: Use one sheet for each position of employment.

Applicant Name (First, Middle, Last)		
Address		
City	State	ZIP Code
Course Date (Month DD, YYYY)	E-mail	
Employer Name		
Employer Address		
City	State	ZIP Code
Immediate Supervisor and/or Program Director	Applicant Job Title	
Employment Date From (Month/Year)	Employment Date To (Month/Year)	

- In the box below, briefly describe your experience providing direct patient care for tobacco dependence. ****These hours must reflect time spent providing one-on-one or group treatment for tobacco dependence.** If you provide group treatment, just claim the time spent with the group. Do not multiply the hours by the number of individuals attending the group.
- Examples of activities that **DO NOT** count toward Service Hours (even if tobacco-related) include: Staffing booths at health fairs, class prep time, responding to program inquiries, teaching other health care professionals, keeping records, (any activity that is not direct patient treatment).

Brief description of direct patient care experience. Do not include other experience that does not reflect direct patient care (see criteria above). **Forms without accompanying justification will not be accepted.**

Number of hours of eligible experience (direct patient care providing tobacco cessation) **Hours Claimed _____

By checking this box, I attest that the completed information is accurate. Accept this as my signature.

Applicant Signature	Date (Month DD, YYYY)	
Immediate Supervisor Signature	Title	Date (Month DD, YYYY)

Office Use Only

Reviewer	Date (Month DD, YYYY)
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