**Tobacco Treatment Specialist Recertification**

**Continuing Education Documentation**

**Directions:** The Breathing Association TTS Certificate is valid for two years. Recertification requires proof of continuing education from an accredited organization, on tobacco cessation, prevention, health policy, or closely related areas such as behavioral health and counseling, with 18 hours training during the two-year interval. Please complete this form **(both pages)** and **attach copies** of certificates demonstrating continuing education hours received. Documents may be scanned and emailed to the contact person listed at the bottom of this form. *Please use an additional sheet if necessary to list continuing education*. An example is provided in the first line of the table for your reference\*.

Name:

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home or Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Personal email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TTS Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date TTS Certificate was received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\*\*\*\*\*\*\*\*\*\* Cost for Recertification is $100.00 \*\*\*\*\*\*\*\*\*\***

 Paying by check or money order: **Y N** please include when mailing application.

 Paying by credit card: **Y N**  after application has been received and reviewed, you will receive an email invoice from

 **Paytrace** allowing you to pay and receive a receipt.

**I attest that the listed continuing education hours were received by me and that the information presented is accurate.**

**Signed Date \_\_\_\_\_**

**Please Mail Forms to:**

 **Heather McCary Phone: 614-437-1521**

 **The Breathing Association Fax: 614-437-1506**

 **788 Mt. Vernon Avenue E-mail** **heather.mccary@breathingassociation.org**

 **Columbus, OH 43203**

\*Please use the table in the second sheet to document your continuing education hours.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Continuing Education** | **Title of Workshop** | **Content Summary** | **Total Hours Received** |
| ***1/1/2015*** | ***Secondhand Smoke: The Dangers*** | ***Session focused on exposure to secondhand smoke.*** | ***1.5*** |
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