



Pennsylvania Department of Health
Pre-Approved Tobacco Cessation Registry

Please type or print the following information:

Contact Person:	Name of Health Care Delivery System/Clinic/Individual Practice:
Title:	Street Address:
Phone: Fax:	City: State: Zip Code:
E-mail Address:	Phone: Fax:

Cessation Counselor(s): (Add additional page(s) as necessary)

- Name: _____
Professional Discipline: _____
 I include the certificate of completion from the [cessation registry webinar](#)
- Name: _____
Professional Discipline: _____
 I include the certificate of completion from the [cessation registry webinar](#)
- Name: _____
Professional Discipline: _____
 I include the certificate of completion from the [cessation registry webinar](#)

Location(s) of Cessation services: (Add additional page(s) as necessary)

- Name of Health Care Delivery System: _____
Street Address: _____ City: _____ Zip Code: _____
h : _____ County: _____ PROMISE #: _____
- Name of Health Care Delivery System: _____
Street Address: _____ City: _____ Zip Code: _____
h : _____ County: _____ PROMISE #: _____

Counseling Services Provided (check all that apply): Group Individual Phone

Client Type(s): <input type="checkbox"/> Adult <input type="checkbox"/> Young Adult (18-24) <input type="checkbox"/> Youth (14-17) <input type="checkbox"/> Pregnant Woman <input type="checkbox"/> LGBT <input type="checkbox"/> Practice Patients <input type="checkbox"/> Other _____	Practice Available Language/Verbal Skills: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
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Medical Assistance information:
If your program is approved, would you like information on your program referred to the Department of Public Welfare for DPW review and approval by Medical Assistance for reimbursement of tobacco cessation services?
 Yes No

Attestation:
 I agree with *Treating Tobacco Use and Dependence, Clinical Practice Guideline: 2008 Update*, for Cessation Program Standards & Regulations: <http://www.ahrq.gov/path/tobacco.htm#Clinic>

Printed Name of Organization Representative: _____
Signature of Organization Representative: _____
Title: _____ Date: _____

For DOH Use:
___ Approved ___ Disapproved

Signature of Department of Health Representative Date

Date Applicant Notified: _____
Date DPW Notified: _____