

STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bill J. Crouch
Cabinet Secretary

Bureau for Medical Services

Cynthia E. Beane Commissioner

PEER RECOVERY SUPPORT SPECIALIST CERTIFICATION APPLICATION FORM

PLEASE CLEARLY PRINT OR TYPE RESPONSES

This application, attestation letter, all reference letters, and a copy of your BMS online certification is to be provided to your employer (Comprehensive or Licensed Behavioral Health Center) as part of your employee file. You should personally keep a copy of all documentation in case your employment changes. Please do not send these documents to the Bureau of Medical Services.

APPLICANT INFORMATION								
Name:		Date of Birth:						
(LAST NAME)	(FIRST NAME)	(MI)	(MM/DD/YYYY)					
Maiden and/or Former Name:	Title: 🗆 M	ir. □ Mrs. □ Ms. □ Other: _						
Telephone:	Last 4 Digits of SSN:							
Address:		City:						
State: Zip	Code:	Today's Date:						
E-mail*:	E-mail*:							
* Notification of application receipt will be issued via email. Individuals without an email account who desire confirmation								
must request a mailed confirmation on the line above.								
APPLICATION TYPE:	☐ INITIAL	☐ RE-CEI	RTIFICATION					
1) Have you experienced any m	Have you experienced any mental health or substance use challenges?							
\square YES \square NO If NO, please	☐ YES ☐ NO If NO, please explain:							
2) Are you currently involved with a personal support and/or recovery system?								
☐ YES ☐ NO If NO, please explain:								
Please include three letters of reference, one page or less in length, from individuals familiar with your service experience. NOTE: References must return their letters to the applicant in a sealed envelope with the Reference's signature across the seal. Letters must be submitted with the application packet.								
Reference Name:								
Reference Name:	Reference Name:							
Reference Name:								

ED	UCATION INFORMATION				
1)	Do you have a High School I	Diploma or GED?	□ YES □ NO		
2)	Name of last school attended:		City:	State:	
3)					
4)	Indicate the highest degree ear	ned: H/S GED Associat	e Bachelors Masters D	octorate Other	r
DD	OFESSIONAL INFORMATION				
	e following statement applies to Qu strict of Columbia, a United States			in any other s	state, tne
1)	Have you ever been licensed, cert	tified, or registered as a F	Peer Recovery Support S	Specialist, or any	У
	other behavioral health profession	al? □ NO □ YES If yes	s, please explain:		
	Credential Type:	ls	sue Date:		
	State/Region:	Expira	tion Date:		
2)	Have you ever:				
	 Had your license, certification subjected to any kind of ditions. Had a complaint filed again to report any complaints. Been convicted of a felony NO YES Attach a page fully explain.	sciplinary action? nst your behavioral health dismissed without med and/or crime that harme	NO □ YES n and/or community prac rit. □ NO □ d another	tice? You do n e YES person?	ot need
SE	RVICE AGENCY INFORMATION				
Age	ency Name:				
Pos	sition:				
Add	dress:				
City	<i>y</i> :	State:	Zip (Code:	
Age	ency Phone Number:		Still Working Ho	ere: 🗆 YES	□ NO
Average Hours per Week:			Supervisor:		
Dat	e Started:	How Long There:			
Pos	sition Type: Full-time Employment	☐ Part-time Employment			
Are	a of Focus: ☐ Substance Use ☐ Co-C	Occurring			
	If you have worked at additional a	gencies, please attach additio	nal page(s) with details using	the format above.	

Effective: October 20, 2020

Peer Recovery Support Specialist (PRSS) Attestation of Recovery

I affirm that I have read and agree to adhere to the National Ethical Guidelines and Practice Standards for Peer

Supporters and understand that violation of these Ethical Standards may result in loss of certification, and							
possibly other penalties.							
Applicant Signature/Date							
Please Print or Type Your Name							
Statement of Personal Recovery							
I, the undersigned individual, affirm that I have successfully pursued my own personal health recovery							
xperience involving the use of alcohol and/or other drugs. I affirm that I have not used any alcohol, opiate,							
narcotic, barbiturate, stimulant, or other drug affecting my central nervous system, or other drug causing							
physical or psychological dependence, to which I was addicted or upon which I was previously dependent,							
within the past two years. I further affirm that I have not used controlled substances which were obtained							
illegally, or mis-used any controlled substances which were obtained with a valid prescription order from a							
licensed health care provider, within the past year. I affirm that in the event I experience a relapse in my							
recovery or experience other psychological or physical health conditions which may interfere with and impair							
my professional functioning, I will seek appropriate therapeutic care, and I will request an inactive status as a							
Peer Recovery Support Specialist for medical reasons for as long as is necessary.							
Applicant Signature/Date							
Please Print or Type Your Name							
(Optional) My present period of continued recovery from alcohol or other psychoactive drugs							
is years and/ormonths.							

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