STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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PEER RECOVERY SUPPORT SPECIALIST CERTIFICATION APPLICATION FORM

PLEASE CLEARLY PRINT OR TYPE RESPONSES

A fillable form is available for download at: **https://dhhr.wv.gov/bms**

APPLICANT INFORMATION

Name: _____ _____ _____ **Date of Birth:** _____
(LAST NAME) (FIRST NAME) (MI) (MM/DD/YYYY)

Maiden and/or Former Name: _____ **Title:** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____

Telephone: _____ **Last 4 Digits of SSN:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Today's Date:** _____

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-CERTIFICATION**

1) Have you experienced any mental health or substance use challenges?

   ☐ 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 (3) Letters of Reference, one (1) 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: _____

EDUCATION INFORMATION

1) Do you have a High School Diploma or GED? ☐ YES ☐ NO
2) Name of last school attended: _____ City: _____ State: _____
3) Indicate the last year of school completed: 6 7 8 9 10 11 12 13 14 15 16+
4) Indicate the highest degree earned: H/S GED Associate Bachelors Masters Doctorate Other

PROFESSIONAL INFORMATION

The following statement applies to Questions 1-8 of this section: ***In West Virginia or in any other state, the District of Columbia, a United States territory, or a foreign jurisdiction,***

1) Have you ever been licensed, certified, or registered as a Peer Recovery Support Specialist, or any other behavioral health professional? ☐ NO ☐ YES If yes, please explain:

   Credential Type: _____ Issue Date: _____

   State/Region: _____ Expiration Date: _____

2) Have you ever:

   - Had your license, certification, or registration to practice suspended, revoked, surrendered or subjected to any kind of disciplinary action? ☐ NO ☐ YES
   - Had a complaint filed against your behavioral health and/or community practice? ***You do not need to report any complaints dismissed without merit.*** ☐ NO ☐ YES
   - Been convicted of a felony and/or crime that harmed another person? ☐ NO ☐ YES

   Attach a page fully explaining the circumstances/details of any questions marked 'YES'

SERVICE AGENCY INFORMATION

Agency Name: _____

Position: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Agency Phone Number: _____ **Still Working Here:** ☐ **YES** ☐ **NO**

Average Hours per Week: _____ **Supervisor:** _____

Date Started: _____ **How Long There:** _____

Position Type: ☐ **Full-time Employment** ☐ **Part-time Employment**

Area of Focus: ☐ **Substance Use** ☐ **Co-Occurring**

If you have worked at additional agencies, please attach additional page(s) with details using the format above.

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 experience 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/or _____ months.