

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: □ Mr. □ Mrs. □ Ms. □ Other:			
Telephone:	Last 4 Digit	s of SSN:		
Address:		City:		
State: Zip	Code:T	oday's Date:		
E-mail*: * Notification of application receipt wil must request a mailed confirmation or	l be issued via email. Individual		count who desire confirmation	
APPLICATION TYPE:		🗆 R	RE-CERTIFICATION	
1) Have you experienced any me	ental health or substance us	e challenges?		
□ YES □ NO If NO, please	explain:			
2) Are you currently involved with	n 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:

EDUCATION INFORMATION 1) Do you have a High School Diploma or GED? YES DNO 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? Indicate Type: Issue Date: State/Region: Expiration Date: 2) Have you ever: Expiration Date:

- ➤ Had your license, certification, or registration to practice suspended, revoked, surrendered or subjected to any kind of disciplinary action?
- 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
 VES

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

SERVICE AGENCY INFORMATIO	N		
Agency Name:			
Position:			
Address:			
City:	State:	Zip Code:	
Agency Phone Number:		Still Working Here: 🛛 YES	
Average Hours per Week:	s	Supervisor:	
Date Started:	How Long There:		
Position Type: 🛛 Full-time Employme	ent 🛛 Part-time Employment		
Area of Focus: Substance Use C	Co-Occurring		
If you have worked at addition	nal agencies, please attach additional pa	age(s) with details using the format abov	e.

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.