Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Application for Ohio Peer Recovery Supporter Re-Certification

Part 1- Contact Information

Date:	
Name:	
Present Address:	
County of Residence:	
Phone :	**Alternate Phone:**
Email Address:	
Preferred Method of Contact:	

PART II- Training Log

Please list completed 30 hours of trainings or workshops (continuing education and/or in-service) pertaining to your ongoing skill development to enhance your role as an Ohio Certified Peer Recovery Supporter.

☐ Complete the OPRS Certification Training Log that details the number of contact hours for each course and include it with your application and copies of certificates.

Training	Date	Hours	Location

APPENDIX p(164438) pa(297960) d(642614) ra(497432) print date: 06/10/2016 8:00 PM

Do you have any other Certifications or Licenses? ❑ No ❑ Yes, Please list:		
Certification/License Name	**State Authority**	**Date of Expiration**

Part III – Supplemental Information (Does not preclude recertification approval)

Have you served in the military?
Do you have foreign language or American Sign Language skills? If yes, please explain.
Do you have experience working with special populations? If so, please circle all that apply. ☐ **Homelessness** ☐ **Mental Illness** ☐ **LGBT** ☐ **Veterans** ☐ **Transitional Age Youth** ☐ **HIV** ☐ **Substance Use Disorder** ☐ **Aging** ☐ **Deaf and Hard of Hearing** ☐ **Cultural Diversity** ☐ **Trauma** ☐ **Other:_____** ☐ **Criminal Justice** ☐ **Nursing Home Transitions**
Have you been convicted of a criminal offense? If so, please explain.

PART IV- Current Employment/Volunteer Experience

Are you currently employed as a Certified Ohio Peer Recovery Supporter: ❑ Yes ❑ No - *see*

2 and 3 below
(1) If yes,
What is your job title? _____
Name of employer? _____
How many hours do you work a week? _____
What is your hourly wage? _____
How long have you been employed in this position? _____

(2) If no, are you looking for work as an Ohio Certified Peer Recovery Supporter?
_____

(3) If no, are you currently working in another capacity?
What is your job title? _____
Name of employer? _____
How many hours do you work a week? _____
What is your hourly wage? _____
How long have you been employed in this position? _____

I verify that I have given true, accurate, and complete information on this form to the best of my knowledge. I certify that I am at least 18 years of age and am currently in recovery. I verify that I am an individual with a lived experience of a mental health and/or substance use disorder. I understand that any false information/omissions may be grounds for rejection of my application or corrective action. I verify that I have only acted in ways which did not abuse, neglect or exploit another person during my work or volunteer experience. I verify that I will follow the Ohio Peer Recovery Supporter Pledge set forth by OhioMHAS and the provider for which I work or volunteer. I understand that acceptance of this application indicates only that I have the necessary experience, training, and supervision to work in the capacity of a Certified Ohio Peer Recovery Supporter. All personal information provided in this form will remain confidential and data will only be used in graphs creating a non-identifying profile of those completing the certification process unless otherwise indicated. My primary obligation and responsibility is to my personal recovery.

Signature of Applicant _____ **Date** _____

Optional:
OhioMHAS has my permission to include my name, certification date, and region of the state in a database that employers may access for hiring/volunteer recruiting purposes.
Optional:

Signature of Applicant_____ **Date**_____

I understand that upon approval of my re-certification application, earning a passing score on the Ohio Mental Health and Addiction Services exam, and verification of a criminal background check. I understand that Ohio Mental Health and Addiction Services may revoke my certification if the below can be substantiated:

- Violation of 5122-29-15 and 5122-29-15.1
- Violation of the Peer Recovery Supporter Pledge as determined through the Conflict of Interest process.

Mandatory:
Signature of Applicant_____ **Date**_____

Mandatory:
Signature of Applicant _____ **Date**_____

The complete application packet should be mailed to:

Ohio Certified Peer Recovery Supporter
OhioMHAS
30 East Broad Street, 36th Floor
Columbus, Ohio 45601

*** Recertification Date Notice of Change in Practice ***

Recertification packets are mailed to Ohio Mental Health and Addiction Services 60 days prior to the certificate expiration date. Recertification dates will be based on the month and day of initial certification. Certificates will not be issued based on the date of approval of recertification packets.

OhioMHAS Staff or Designee Only:

	Date	Yes	No	Comments
Application Received				
Attachments Reviewed				
References Contacted				
Updated Ohio BCI Background Check Received and Approved				
Re-certification Approved				