PEER SUPPORT SPECIALIST APPLICATION DESIGNATION FORM

Certified Peer Support Specialist seeking certification in an additional area of designation

I am completing an application for training in the following CPSS area of designation:

❑ Parent/Caregiver ❑ Young Adult ❑ Adult ❑ Recovery

Directions: This form is to be completed by the Applicant. Type or print ALL INFORMATION; fill in every blank and/or check the appropriate boxes. The application MUST BE properly notarized and signed.

Personal Information

1. a. Name: ❑Mr. ❑Ms. _____

(Type or Print name EXACTLY as it should appear on the certificate.)

b. Name(s) used on Records if different from above: _____

2.

Current Employment Information

Position	
Organization	
Street Address	
City, State, Zip	
Telephone Number	
Supervisor Name	

3. **Please complete only if information has changed since initial application**

Home Street Address		
City, State, Zip		
County of Residence		
Numbers	Home Number:	Cell Number:
Email Address		

The Division of PLACE will need to correspond with you regarding your application materials and/or related matters; **an email address and accurate mailing address is mandatory. The Division of PLACE must be notified of any address changes during the certification process.**

4.

Forms

Please review, complete and submit forms for the appropriate designation:

Scope of Activities Form www.dmh.ms.gov/cpss-documents
Information Gathering Form www.dmh.ms.gov/cpss-documents
Verification of Employment Form www.dmh.ms.gov/cpss-documents
Assurance and Release Form www.dmh.ms.gov/cpss-documents

APPLICATION MUST BE NOTARIZED BELOW:

-AFFIDAVIT-

State of _____ **County of** _____

The undersigned, being sworn, deposes and says that he/she is the person who completed this application; that the statements contained herein are true in every respect; **that he/she has read the *DMH Peer Support Specialist Professional Standards & Requirements* document and the *DMH Peer Support Specialist Professional Principles of Ethical & Professional Conduct* and will conform to these *Standards & Requirements* and *Principles*;** that DMH (and its representatives) has the right to contact any person/organization in reviewing this application and/or in maintenance of certification; that he/she authorizes the release of any information requested by DMH (and its representatives) in reviewing this application and/or in maintenance of certification; that he/she understands that upon certification, certain certification data are considered public information; that he/she releases DMH (and its representatives) from all liability and claims arising from any services (if any) rendered by the undersigned; that he/she has read and understood this affidavit; that he/she understands that all application materials become the property of DMH and will not be returned.

_____
Applicant's Signature

_____
Legal Representative's Signature Date
(If applicable, please provide documentation)

Official Seal

Subscribed and sworn to before me this _____

Day of _____, 20_____.

_____
Signature of Notary Public

My commission expires on _____.

SUBMIT YOUR FORMS TO

Mississippi Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201
ATTN: Certified Peer Support Specialist Professional

For more information please visit our website at www.dmh.ms.gov

HAND DELIVERED APPLICATIONS WILL NOT BE ACCEPTED!!