

# 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

Mr.

1. a. Name:  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 <u>Street Address</u>		
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](http://www.dmh.ms.gov/cpss-documents)
- Information Gathering Form [www.dmh.ms.gov/cpss-documents](http://www.dmh.ms.gov/cpss-documents)
- Verification of Employment Form [www.dmh.ms.gov/cpss-documents](http://www.dmh.ms.gov/cpss-documents)
- Assurance and Release Form [www.dmh.ms.gov/cpss-documents](http://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

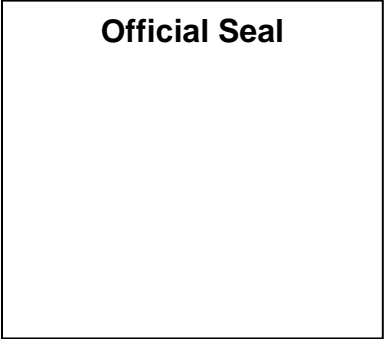
\_\_\_\_\_  
Legal Representative's Signature Date  
(If applicable, please provide documentation)

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](http://www.dmh.ms.gov)

**HAND DELIVERED APPLICATIONS WILL NOT BE ACCEPTED!!**