

Michigan Certification Board for Addiction Professionals

CERTIFICATION MANUAL

For

Certified Peer Recovery Mentor

(IC&RC reciprocal)

CPRM

Certified Peer Recovery Mentor (CPRM)

Directions for Submitting Application

Completion of this packet of forms and submission of supporting documentation constitutes your Certification Application. Please note that this is not a career portfolio. You are only required to submit material sufficient to meet the requirements of the certification for which you are applying. All information must be typed or printed legibly.

This packet of forms is intended to help make your application compilation as easy as possible, within the constraints of the requirements of the level of certification you are seeking. If you have any questions, please refer to the appropriate sections in the full application manual. If you still have questions, please call the MCBAP office at (517) 347-0891.

Submit your application forms in the following order with supporting documents.

1. Application – (Submit copy of any legal name change documents) (Form #1).
2. Application Review Check List (Form #2)
3. Experience – Documentation of Experience Form(s) (Form #3).
4. Supervised Practical Training - Supervised Practical Training Form(s) (Form #4).
5. Education – Education Summary Sheet (Form #5)
6. Documentation of Education Forms (Forms #5A- 5F)
7. Code of Ethics and Testing – (Proof of Education and Testing) (Form #6)
8. Sign Code of Ethics (Form #7).
9. Fees & mailing Instructions – Submit all forms, documentation and \$65.00 (check or money order) non-refundable two-year certification fee payable to MCBAP.

Mail to:
MCBAP
6639 Centurion Drive
Suite 170
Lansing, MI 48917

**Certified Peer Recovery Mentor
(CPRM)**

APPLICATION
(all information must be typed or printed)

I - Personal Information

Name _____
(as you want it to appear on your certificate)

Address _____
Street Apt.

_____ City County State Zip Code

Email Address _____ Highest Level of Education _____

Program/Business Name _____

Program/Business Address _____
Street Suite

_____ City State Zip Code

Home Telephone _____ Business Telephone _____ Soc.Sec.Number
(Last 4 digits only)

II - Signature Requirement

I hereby certify that all of the information being submitted in this application is true and accurate and that I have read, signed, and ascribe to the accompanying MCBAP Code of Ethical Standards.

Applicant's Signature _____ Date _____

The certification fee is \$65.00 for two-years. Please attach a check or money order made payable to MCBAP. This is a non-refundable application fee. Please mail to: MCBAP, 6639 Centurion Drive. , Suite 170, Lansing, MI 48917

Certified Peer Recovery Mentor (CPRM)

APPLICATION REVIEW CHECKLIST

Applicant's Name _____

**THIS SIDE OF PAGE
FOR APPLICANT USE ONLY**

**THIS SIDE OF PAGE
FOR STAFF USE ONLY**

APPLICATION
 Completed and signed _____
 Documentation of name change if required _____

APPLICATION
 Completed and signed _____
 Documentation of name change if required _____

EXPERIENCE
 Total number of hours _____

EXPERIENCE
 Total number of hours _____

SUPERVISION
 Total number of hours _____

SUPERVISION
 Total number of hours _____

GENERAL EDUCATION
 High School/GED/College _____

GENERAL EDUCATION
 High School/GED/ College _____

SPECIALIZED EDUCATION
 Total number of hours _____

SPECIALIZED EDUCATION
 Total number of hours _____

Number of Peer Mentor-Domain hours _____

Number of Peer Mentor-Domain hours _____

Advocacy hours _____
 Mentoring / Education hours _____
 Recovery and Wellness hours _____
 Ethical Responsibility hours _____
 Clinical Ethics course hours _____
 MAFE Test Passed for hours _____

Advocacy hours _____
 Mentoring / Education hours _____
 Recovery and Wellness hours _____
 Ethical Responsibility hours _____
 Clinical Ethics course hours _____
 MAFE Test Passed for hours _____

CODE OF ETHICS
 Signature _____

CODE OF ETHICS
 Signature _____

TESTING
 Passing Score _____

TESTING
 Passing Score _____

This checklist should be the second document in your application packet. This checklist provides a location for you to record compliance with certification criteria, and a location for MCBAP staff to record the outcome of their review of the documents you have submitted.

Certified Peer Recovery Mentor (CPRM)

DOCUMENTATION OF EXPERIENCE

Section I - Applicant Information *(All information must be typed or printed.)*

Name _____

Section II - Program Information

Program Name _____

Program Address _____

Street

City _____ State _____ Zip Code _____

Daytime Phone Number _____ Michigan License # _____

Section III - Documentation of Experience (attach a copy of the applicant's job description).

Applicant's position _____

Beginning date _____ Ending date _____

Write below the average number of direct and indirect hours per week the applicant spent in the addiction peer mentor / recovery support activities, representing functions of the IC&RC Peer Recovery Mentor Performance Domains (Full time positions may enter 40 hours) _____

Section IV

By signing below, I attest that the applicant named in Section I worked as a Peer Mentor / Recovery Support professional at this program providing client support services.

Supervisor or Program Director PRINT and SIGN _____ Date _____

Certified Peer Recovery Mentors are required to have 500 or more hours of experience in the functions of the IC&RC Peer Recovery Mentor Performance Domains. This form should be completed by the program director or supervisor of the program in which the experience was gained. If the experience was in several programs, each program supervisor should complete this form.

SUPERVISOR: Please complete and sign this form and return it to the applicant with a copy of the applicant's job description, for submission with his/her Certification Application.

APPLICANT: Please enter the total number of documented experience hours on the Application Checklist.

Certified Peer Recovery Mentor (CPRM)

EDUCATION SUMMARY SHEET

Section I - Applicant Information

Name _____

Section II – General Education:

All applicants must be able to provide verification of the completion of a High School or GED diploma, or higher degree from an accredited college or university.

Section III - Education Event Information

Complete the education documentation form(s) for courses and workshops attended.

46 Hours Minimum – Specific education content required:

- I. _____ contact hours shown in Advocacy topics (10 hours) – Form 5-A
- II. _____ contact hours shown in Mentoring and Education (10 hours) – Form 5-B
- III. _____ contact hours shown in Recovery and Wellness Support (10 hours) – Form 5-C
- IV. _____ contact hours shown in Ethical Responsibility (16 hours) – Form 5-D
- V. _____ additional contact hours for specific required topics* - Form 5-E
- VI. _____ contact hours from Undocumented Education Events – Form 5-F

_____ **Total Hours Education Documented**

***Specific required topics checklist (these may be addressed within the required education hours or may be additional education hours).**

- _____ Confidentiality rules – substance use disorder, mental health, HIV/AIDS (IV)
- _____ State of Michigan mandatory reporting laws and procedures (IV)
- _____ Recipient Rights (IV)
- _____ Ethical behavior and decision making [minimum 6 hours] (IV)
- _____ Communicable disease information, risk management (II)
- _____ Stages of change / stages of recovery (III)
- _____ Managing professional boundaries, role clarification, self-care (IV)
- _____ Motivational interviewing; wellness planning; crisis assistance (III)
- _____ Basics of substance abuse and mental health disorders; co-occurring illness (III,V)
- _____ Role playing, skills practice
- _____ Record keeping and documentation

The Education requirement includes specific numbers of hours and specific topics listed above. The following Documentation of Education worksheets (Forms 5A to 5F) provide forms for each of the sub-requirements listed above. Complete those worksheets, attach certificates-of-completion or other documentation of attendance for the education you list, and total the number of hours on this cover sheet. Remember, you do not need to document hours over the required hours/topics. Form 5F allows you to include in-service and undocumented training, if you have the signature of your program director or supervisor who has knowledge of or has reviewed alternative documentation for that training. If you have completed a recovery support education program, contact MCBAP to determine whether the program is applicable. After completing these forms, transfer the information to this cover sheet and complete the Education Documentation hours summary items on the Application Check List (Form # 2).

Certified Peer Recovery Mentor (CPRM)

DOCUMENTATION OF EDUCATION Peer Mentor Performance Domain Categories

Document each training course, seminar, workshop, etc., date(s) and contact hours using this format. **This form should reflect only education courses or seminars in topics specific to the Peer Recovery Mentor Performance Domains (I – IV).** Attach certificates of completion or other documentation verifying attendance at the below listed educational events. (You only need to document the minimum standard)

Name _____

_____ **Contact Hours in Advocacy for peer support services**

<u>Title and sponsor or provider of training course, workshop, seminar, etc.</u>	<u>Date(s)</u>	<u>Contact Hours</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check here if hours for this Domain are listed on Form 5-F. # Hours on 5-F: _____

Requirement: 10 hours of education in Advocacy for peer recovery support. Total the hours listed here and enter them on the appropriate line on the Education Cover Sheet (Form # 5).

Certified Peer Recovery Mentor (CPRM)

DOCUMENTATION OF EDUCATION Peer Mentor Performance Domain Categories

Document each training course, seminar, workshop, etc., date(s) and contact hours using this format. **This form should reflect only education courses or seminars in topics specific to the Peer Recovery Mentor Performance Domains (I – IV).** Attach certificates of completion or other documentation verifying attendance at the below listed educational events. (You only need to document the minimum standard)

Name _____

_____ **Contact Hours in Mentoring and Education for peer support.**

<u>Title and provider of course, workshop, seminar, etc.</u>	<u>Date(s)</u>	<u>Contact Hours</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check here if hours for this Domain are listed on Form 5-F. # Hours on 5-F: _____

Requirement: 10 hours of education in Mentoring / Education for peer support. Total the hours listed here and enter them on the Education Cover Sheet (Form # 5).

**Certified Peer Recovery Mentor
(CPRM)**

**DOCUMENTATION OF EDUCATION
Peer Mentor Performance Domain Categories**

Document each training course, seminar, workshop, etc., date(s) and contact hours using this format. **This form should reflect only education courses or seminars in topics specific to the Peer Recovery Mentor Performance Domains (I – IV).** Attach certificates of completion or other documentation verifying attendance at the below listed educational events. (You only need to document the minimum standard)

Name _____

_____ **Contact Hours in Recovery and Wellness for peer support.**

<u>Title and provider of course, workshop, seminar, etc.</u>	<u>Date(s)</u>	<u>Contact Hours</u>

Check here if hours for this Domain are listed on Form 5-F. # Hours on 5-F: _____

Requirement: 10 hours of education in recovery process and wellness planning and promotion for peer support. Total the hours listed here and enter them on the Education Cover Sheet (Form # 5).

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EDUCATION FORM FOR UNDOCUMENTED EVENTS

This form is to be used to verify undocumented education. If you don't have certificates of completion for a course, seminar, or workshops, you must fill out this sheet and have your supervisor or program director sign the bottom to verify that you have received this education. **Listing education events on this form should be the exception in your documentation.** You should make every effort to locate missing verification of educational hours before using this form. This form can also be used to document in-service education. Indicate which topic of education the entry applies to by listing the appropriate Domain number or topic abbreviation at the end of the line. Use more than one form copy if you are listing events from more than one supervisor.

Name _____

<u>Title and provider of education:</u>	<u>Date(s)</u>	<u>Contact Hours</u>	<u>Domain # (I,II,III,IV) or Topic</u>

By signing this form, I attest that the above applicant has attended the undocumented education sessions listed on this form (5F), and that the education provided was relevant to addiction oriented peer recovery mentoring and support services.

Supervisor/Program Director PRINT and SIGN Date

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General Education, Ethics Education, and Testing

General Education - All applicants must be able to provide verification of the completion of a High School or GED diploma, or higher degree from an accredited college or university. (Documentation must be submitted)

Date

Ethics Education – submit certificate(s) of completion

Course Title

Date

Contact Hours – 6 hours minimum total

Company/Organization

Trainer (name)

Testing – enter date in space provided and submit a copy of verifying document for the exam

IC&RC/CPRM examination pass on _____

Ethics education is required for for all certified professionals. Ethics education for CPRM-M may be completed either in-person (face-to-face), through online/distance learning, or a combination. Given the limited availability of ethics training specific to peer recovery mentor support, ethics education may be met by courses on more general professional counseling ethics, addiction services ethics, social work ethics, or similar.

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CODE OF ETHICS AGREEMENT

I, the undersigned individual, affirm that I have read and I agree to adhere to the MCBAP Code of Ethical Standards for Professionals and understand that violation of these Ethical Standards may result in loss of certification, and possibly other penalties. [Appendix B]

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 or affected by the use of alcohol and/or other drugs. I affirm that I have not used any alcohol, narcotic, barbituate, 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 year. I further affirm that I have not used controlled substances which were obtained illegally or which were not 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 over an extended period of time, I will seek appropriate therapeutic care, and I will request an inactive status with MCBAP for medical reasons for as long as is necessary.

(Optional) My present period of continued recovery from alcohol or other psychoactive drugs is _____ years.

Applicant Signature

Date

Please Print or Type Your Name

Certified Peer Recovery Mentor (CPRM)

Data Collection Form

This data is important in identifying the on-going status of substance abuse services workforce in Michigan. The information will assist with identification of future needs, e.g. competency standard, credentialing, training, education, future funding and other planning activities. The aggregate data will be shared with groups such as providers, Prepaid Inpatient Health Plans, Office of Drug Control Policy, elected officials and other interested parties. No individual data will be disclosed.

Type of service setting in which you spend the majority of your work time

- | | |
|--|--|
| <input type="checkbox"/> Prevention | <input type="checkbox"/> Detoxification |
| <input type="checkbox"/> Residential | <input type="checkbox"/> Intensive Outpatient |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> Methadone- OTP |
| <input type="checkbox"/> Management/Administration | <input type="checkbox"/> Jail / Prison / Court |
| <input type="checkbox"/> Medical Clinic | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Access – Referral Center | <input type="checkbox"/> Other: _____ |

Typical hours worked per week in substance abuse treatment, prevention, recovery work

_____ Hours

Primary role/responsibility function(s)

- | | |
|---|--|
| <input type="checkbox"/> Primary Therapist / Professional | <input type="checkbox"/> Didactics Groups |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Intake / Screener |
| <input type="checkbox"/> Clinical Supervisor | <input type="checkbox"/> Medical/Psychiatric |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Services Aide |
| <input type="checkbox"/> Recovery Support | <input type="checkbox"/> Student Intern |
| <input type="checkbox"/> Educator | <input type="checkbox"/> Other _____ |

Annual income from treatment or prevention work (optional)

- | | | |
|--|--|---|
| <input type="checkbox"/> \$ 0 - \$10,000 | <input type="checkbox"/> \$31,000 - \$40,000 | <input type="checkbox"/> \$61,000 - \$70,000 |
| <input type="checkbox"/> \$11,000 - \$20,000 | <input type="checkbox"/> \$41,000 - \$50,000 | <input type="checkbox"/> \$71,000 - \$80,000 |
| <input type="checkbox"/> \$21,000 - \$30,000 | <input type="checkbox"/> \$51,000 - \$60,000 | <input type="checkbox"/> \$81,000 – \$90,000 plus |

Gender (optional) Female Male

Primary Race/Ethnic Group (optional)

- | | |
|--|---|
| <input type="checkbox"/> White/Caucasian (non-Hispanic) | <input type="checkbox"/> Asian American |
| <input type="checkbox"/> Black/African American (non-Hispanic) | <input type="checkbox"/> Native American/Indian |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Alaska Native |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Arab/Chaldean |
| <input type="checkbox"/> Other (please specify) _____ | |

Certification(s)/Licensure(s) Held (List ALL and if temporary or expired status)
