

Mental Health America National Certified Peer Specialist APPLICATION FOR CERTIFICATION

Effective Date: 3-1-17

DIRECTIONS

Applicants must establish an online account with the FCB. A 'how to' is posted online at <http://flcertificationboard.org/resources/training-and-tutorials/> DO NOT submit this application, fees or supporting documentation until you have created your account as the FCB will not be able to conduct any business with you *until* your online profile is created. The primary means of communication is by email. You MUST have an active email account. As your credential(s) belong to you, we strongly recommend you use your primary personal email and mailing addresses for FCB contact purposes.

1. Complete and submit this application and the certification fee of \$225 to the FCB via:
US Mail: FCB ♦ 1715 South Gadsden Street ♦ Tallahassee, FL 32301
Email: admin_assist@flcertificationboard ♦ Subject: MHA NCPS Application for Certification
2. The FCB holds applications/supporting documentation without payment for 30 calendar days.
Credit card payment by phone: The FCB accepts VISA, MasterCard, Discover and American Express at 850-222-6314. The \$5 credit card processing fee is waived for MHA NCPS applicants.
Check or Money Order by US Mail: Include check/money order payments with this application.
3. You will not be able to conduct any business with the FCB

Part 1: Applicant Information. Provide requested information EXACTLY as it is associated with your FCB account.

Full Name

Email Address
Part 2: Other Certification or Licensure
Do you hold any other current license or certification? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, please identify the credential(s) you hold and attach a copy of the credential. Attach additional sheets if necessary.
Credential Name: _____
Issuing Authority: _____
Issue Date: _____ Expiration Date: _____
Part 3: Formal Education/Degree
Report the highest level degree you hold that meets or exceeds the minimum requirement of a High School Diploma/GED.
Degree: <input type="checkbox"/> HSD/GED <input type="checkbox"/> AA/AS <input type="checkbox"/> BA/BS <input type="checkbox"/> MA/MS <input type="checkbox"/> Other _____
Major: _____
Institution: _____
Award Date: _____
*A copy of your HSD/GED or an unofficial college/university transcript must be included with your application.

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Part 4: MHA NCPS Content-Specific Training Requirement

Please select one of the following and attach supporting documentation.

I hold a current state certification that required me to complete a minimum training requirement of 40 hours.*

I hold a certificate of completion of an MHA approved training program.**

**Attach a copy of your current credential and the published standards for the credential, including training requirements.*

***Attach a copy of your certificate of completion. Eligible documentation must include: your name; the title of the course/training event; the sponsor/provider; the delivery date(s); and the number of contact hours. In the absence of complete documentation, contact the provider for documentation of required information on their official letterhead: Submit these letters with their original supporting documentation (unless none exists.)*

Part 5: References

Identify the individuals who will submit your letters of recommendation for certification.

Reference 1: Letter of Recommendation

Recommender's Name: _____

Contact Email _____ Contact Phone #: _____

Type of Recommendation Professional Supervisory

Reference 2: Letter of Recommendation

Recommender's Name: _____

Contact Email _____ Contact Phone #: _____

Type of Recommendation Professional Supervisory

Part 6: Related Work Experience

List employer(s) where you gained eligible paid or volunteer work experience (attach additional pages if necessary).

Employer 1:

Employer Name: _____

Employer Street Address: _____

Employer City-State-Zip code: _____

Position Title: _____

Start Date: _____ End Date: _____ Hours per week: _____

Employer 2:

Employer Name: _____

Employer Street Address: _____

Employer City-State-Zip code: _____

Position Title: _____

Start Date: _____ End Date: _____ Hours per week: _____

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Part 7: Application Attestation

By my signature below, I attest that:

1. I am applying to the Florida Certification Board (FCB) for Mental Health America's National Peer Specialist certification. I understand that Mental Health America (MHA) has partnered with the Florida Certification Board to develop and administer this credential on behalf of Mental Health America. I understand that I am subject to the scope of service (roles, responsibilities, and limitations) as directed by MHA and the FCB in regard to the National Certified Peer Specialist (NCPS) credential.
2. I have received, read and understand the credential-specific standards table for the credential I am seeking and agree to abide by all terms and conditions therein.
3. I understand that certification award is contingent upon my successfully meeting all applicable MHA NCPS certification standards and requirements.
4. I understand that false or misleading statements or omission of information may result in the denial or revocation of certification.
5. I give my permission to the FCB and its staff to investigate my background as it relates to information contained in my application for certification.
6. I consent to the release of information contained in my application, certification record(s) and/or any other pertinent information to FCB staff and members of the FCB Board of Directors and its Advisory Boards, Councils and review committees.
7. I understand the FCB will publish my name, credential information and any history of ethical misconduct/disciplinary action in response to public searches made through the FCB online credential verification system.
8. I agree to hold the FCB, its staff, members of the FCB Board of Directors and members of FCB Advisory Boards, Councils and review committees free from any civil liability for damages resulting for any actions that is within the scope of the performance of their duties which is taken in connection with the review of this application for certification, subsequent examinations, allegations of ethical misconduct, disciplinary proceedings and implementation of FCB policy which may result in denial or revocation of certification for cause.
9. I understand that FCB certification related fees are non-refundable, even if it is determined that I am not eligible for certification for any reason.
10. I hereby affirm that the information provided in this application is correct and that I believe that I am qualified for the level of certification for which I am applying.

Signature (FCB accepts both manual and electronic signatures)

Date