Department of Behavioral Health
and Developmental Services
Office of Recovery Services

Peer Recovery Specialist Trainer Application

Please complete and sign this application electronically, and send together with Trainer Application Experience Chart and Motivation Letter* to DBHDS Peer Recovery Specialist Liaison Mary McQuown – mary.mcquown@dbhds.virginia.gov

First name:	
Last name:	
Email:	
Organization/Agency and website:	
Address:	
Office Phone: Mobile Phone:	
Job Title: Length of time in current position:	
Are you a trained Peer Recovery Specialist? Are you Certified? Name of Certification and which State Certification is held:	___ Yes ___No ___ Yes ___No
Have you trained adult students within the past 3 years? **If yes, complete the Trainer's Experience Form and attach.**	___ Yes ___No

Peer Recovery Specialists are required to role model a recovery journey of their personal experience with behavioral health challenges (mental health and/or substance use disorder) **OR** their experience as a parent of a child with mental illness and/or substance use disorder, or as a family member of an adult with an on-going and/or personal experience with mental illness and/or substance use disorder. Do you self-identify as a person who would qualify as a Peer Recovery Specialist?

___ Yes ___No

Please refer to the attached map marked PRIMARY DBHDS Regions and list the PRIMARY Region in which you would be providing training if selected:

Please indicate any proficiencies related to your ability to mobilize and train diverse, minority, or otherwise challenged populations:

Please explain membership and/or affiliations with organizations that may benefit from having a PRS Trainer (i.e. State-wide Non-profit, Regional Partnership, etc.):

***Please submit** one (1) page **Motivation Letter (**not to exceed 400 words), describing in your own words what peer support is and why it is an important component of quality health care support.

Please refer to the attached PRS ToT Training Schedule and indicate your primary and secondary choice for training if selected:
FIRST CHOICE REGION/DATES ___(this will change accordingly)____________________
SECOND CHOICE REGION/DATES _______________________

Do you have any special needs for participation (e.g. dietary or other requirements/accommodations)?

BY SIGNING AND SUBMTTING THIS APPLICATION FOR TRAINER OF THE DBHDS PRS TRAINING CIRRICULUM, I DO HERBY AGREE TO COMPLETE ONE (1) TRAINING FOR TWELVE (12) STUDENTS WITHIN SIX (6) MONTHS OF COMPLETING THE TRAINING OF THE TRAINER, AT NO CHARGE TO THE 12 STUDENTS. After meeting this commitment, I will be able to set my own fees for subsequent classes.

I DO ATTEST THAT AS A DBHDS-APPROVED TRAINER, I WILL FOLLOW THE DBHDS-APPROVED CPRS CURRICULUM IN ALL TRAININGS THAT I CONDUCT, AND COMPLETE ALL REQUIRED REPORTING IN A TIMELY MANNER.

I UNDERSTAND THAT DBHDS CAN AND WILL CONDUCT WRITTEN AND ONSITE EVALUATIONS OF TRAININGS IN ORDER TO INSURE FIDELITY TO THE CURRICULUM IS MAINTAINED.

SIGNATURE____ **DATE**___________________________________