



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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you Certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Certification and which State Certification is held:	
Have you facilitated adult learners within the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, complete the Trainer's Experience Form and attach.	

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** a 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.

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

BY SIGNING AND SUBMITTING THIS APPLICATION FOR TRAINER OF THE DBHDS PRS TRAINING CURRICULUM, 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 _____