*Missouri*
*Credentialing Board*

(573) 616-2300 www.missouricb.com 428 E. Capitol, 2nd Floor
e-mail: help@missouricb.com Jefferson City, MO 65101

## Criteria for Certified Reciprocal Peer Recovery (CRPR)

# I. Criteria

- Minimum of HS Diploma/HSE
- 500 hours of applicable work/volunteer experience within the last 10 years
- Professional Reference Form from one of the following professionals: CADC, CRADC, CRAADC, CCJP, CRPS, MAPS, RADC, RADC-P, CCDP, CCDP-D, LPC, LCSW, Licensed Psychologist, or Director of a certified recovery support program.
- 46 hours of training/education as follows:
  - 10 hours in Advocacy
  - 10 hours in Mentoring/Education
  - 10 hours in Recovery/Wellness Support
  - 16 hours in Ethical Responsibility
- 25 Performing hours of Supervised Practicum in the IC&RC peer recovery domains
- Pass the IC&RC International Peer Recovery Examination

**APPLICABLE WORK/VOLUNTEER EXPERIENCE**
Work/Volunteer experience is defined as experience in the Peer Recovery domains. Experience as a volunteer, intern, or unpaid practicum qualifies as work experience if the experience is the same that a paid employee would perform.

All qualifying experience must have been accrued during the ten (10) years immediately prior to application being made.

All experience must be verified by a Work/Volunteer Verification form from the organization(s) in which the applicant has experience.

**SUPERVISED PRACTICUM IN THE PERFORMANCE DOMAINS** is defined as providing the performance domains while under supervision.

The supervision of the experience of providing the performance domains may take place within an academic setting and/or within a supervised work setting. The goal is to receive supervised experience in all of the performance domains.

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# CHECK LIST FOR CRPR APPLICATION

1. You have submitted a $200.00 check with this application or have provided your credit/debit card information on page 5 of this application packet. **Applications will not be reviewed until payment is received.**
2. You have completely filled out the application.
3. You have signed the CRPR Code of Ethics.
4. You have filled out the Family Care Safety Registry Worker Registration Form and included the form with your packet. If your agency has conducted a FCSR background check on you within the last 30 days, you may submit the results to help expedite the application process.
5. The appropriate person has completed and signed the Work/Volunteer Verification Form and you have included the completed form with the application.
6. The Supervised Practicum form has been completed by an appropriate professional and been included with the application.
7. The appropriate certificates were included to verify the required educational/training hours.
8. The appropriate High School/HSE or College transcripts were included.
9. The Reference Form has been filled out by a Qualified Professional Reference and been included with the application.
10. Typically, applications are reviewed within two weeks of receipt in the MCB office. If you have not received written correspondence from the MCB 3 weeks after mailing your application, call the MCB.
11. Check the Professional Search on the MCB website homepage at www.missouricb.com. Type in your last name. If your application is complete, your credential information will be displayed and you should have received your welcome letter and certificates by e-mail.
12. Refer to the Peer Recovery Candidate Guide on the MCB website www.missouricb.com under the Education Box/Candidate Guide link for the Peer Recovery domain definitions.

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# Application Instructions:

1. Requirements to receive this credential are subject to change without notice. Please make sure you are submitting the most recent application packet. If you are unsure, contact the MCB office.
2. The application must be typed or **neatly printed.**
3. Please keep a copy of all materials submitted for your records.
4. FEES: The total CRPR Fee is $200.00. You may pay by check, money order, or provide credit card information on page 5 of this application packet. **Applications will not be reviewed until payment is received.**
5. Please be aware that should your application be reviewed and additional information is requested to complete the application, you will have 90 days to provide the requested information. Failure to do so will result in your application expiring without being approved.
6. All fees are non-refundable. If your application is denied or expires, fees will not be refunded.
7. If your application is denied, you may contact the MCB office staff for instructions on how to appeal the denial of your application.
8. All materials submitted to the MCB office become property of the MCB.
9. The applicant must currently reside and/or work/volunteer in the State of Missouri at least 51% of the time. The only exception to this is applicants living and working in a state that is not a member of the International Certification and Reciprocity Consortium.
10. The CRPR credential has a 2 year renewal and for each renewal, a professional needs 20 total CEUs with 6 of those being live ethics.
11. Please remember that it is your responsibility to keep the MCB office informed of any personal informational changes such as address and phone number changes. If you fail to notify us of changes, you will be responsible for any material that is mailed to the wrong address and will have to pay a fee to have the material sent again.
12. **Please <u>mail</u> your application to the MCB. Please do <u>not</u> fax or e-mail your application.**

# Useful Information:

1. If at any time during the application process, a question arises regarding an applicant's moral character, reputation for honesty, integrity, or professionalism, the Board may deny the application at that time or place the application on hold until an investigation has been done and a decision made regarding the question brought up.
2. Once your application has been accepted and has final approval, you will receive a letter from our office with further instructions on how to continue the application/testing process. With this letter, you will also receive information on how to obtain a free Candidate Guide from our web site. This guide provides you sample questions for the exam.
3. The CRPR credential is a reciprocal credential with other IC&RC member boards that offer the peer recovery credential. You can contact the MCB office for more information on reciprocity.

## Important Notice To Applicants

According to Missouri Credentialing Board (MCB) Policies and Procedures, the following rules apply to those seeking a MCB credential.

1. No individual currently under any type of court supervision can apply for a MCB credential. Please wait until you are completely free from court supervision before applying.
2. The following items disqualify an individual from ever being credentialed with the MCB:
   A. Is listed on the Department of Mental Health disqualification registry
   B. Is listed on the employee disqualification list of the Dept. Health and Senior Services or Dept. of Social Services
   C. Any crime against a minor
   D. A person who has been convicted of, found guilty to, plead guilty to or nolo contendere to any of the Disqualifying Crime (s) Pursuant to Section 630.170, RSMo. The crime (s) will only disqualify an applicant if the crime (s) were a felony. Please view information about Section 630.170, RSMo on the MCB web site www.missouricb.com under the Disqualifying Crimes Link.
3. If an individual has applied for and been given an exception from the Department of Mental Health, the individual may apply for a MCB credential. Please send in proof of exception with your application.

# APPLICATION

## FOR

# Certified Reciprocal Peer Recovery (CRPR)

**Appropriate fee must be submitted with application.**

**MISSOURI CREDENTIALING BOARD**
**428 E. Capitol, 2nd Floor**
**JEFFERSON CITY, MISSOURI 65101**

**TELEPHONE: (573) 616-2300**

**WEB SITE: www.missouricb.com**

**EMAIL: help@missouricb.com**

Please Mark Credit Card Type:

1. Visa _____
2. MC _____
3. Discover _____

CC Expiration Date: _____/_____

Credit Card #: _____-_____-_____-_____

Credit Card 3 Digit Verification Code: _____

# THIS APPLICATION MUST BE TYPED OR PRINTED NEATLY

All Applications Become the Property of MCB

Applicant's Name: _____
First Middle Last Name Suffix (Jr., II)

_____
Maiden Other Names Used

Current Home Address: _____
Street/PO Box Apt. #

_____
City State Zip County

Home Telephone: _____/_____ SSN: _____-_____-_____

Work Telephone: _____/_____, Ext. _____ Cell Number: _____/_____

E-mail Address: _____

SEX: ☐ M ☐ F BIRTH DATE: ____/____/_____

Are you currently or have you been credentialed or licensed as a Substance Use Disorder Professional by the MCB or any other state or organization? ☐ Yes ☐ No

If yes, which state/organization and when? _____

What is the type of credential/license held with the other state/organization?

_____

Have you ever been **ARRESTED** and/or **CONVICTED** of a felony? ☐ Yes ☐ No

***If yes, please go to the www.missouricb.com website, print off the "Felony Offense Form", fill out the form and submit with your application. If you were convicted of a felony listed in Section 630.170 RSMo (view www.missouricb.com; Disqualifying Crimes link), you may not apply for this credential without an exception from the Department of Mental Health.***

Have you ever knowingly been contacted by a Division of Family Services employee regarding a **CHILD ABUSE** and/or **CHILD NEGLECT** incident involving you? ☐ Yes ☐ No

***If yes, please go to the www.missouricb.com website, print off the "Child Abuse/Neglect Statement", fill out the form and submit with your application. In addition, please contact the Division of Family Services at 573-751-2330 and request a report of the incident to include with this application.***

## Education/Degree Information

Please mark your highest level of education completed:

1. High School Diploma/HSE: _____
2. Addiction Certificate Program: _____
3. Associate Degree: _____ Degree Program: _____
4. Bachelor Degree: _____ Degree Program: _____
5. Master Degree/Higher: _____ Degree Program: _____

An applicant may document High School Diploma or HSE or College/University degree by:

1. Submitting copy of High School Diploma/HSE
2. Submitting official or unofficial College/University transcripts. Please ensure the transcript shows the applicable degree being conferred.

**Where Does the Applicant Currently Work?**

| |
|---|
| Name of Employer: |
| Mailing Address of Employer Street City State Zip Code County |
| Name & Title of Immediate Supervisor: |
| Your Business Phone: Area Code/Telephone Number Extension Fax # Area Code/Telephone Number |

## Training Requirements

All applicants must submit proof of the following live education requirements:

A. 10 hours of Advocacy training
B. 10 hours of Mentoring/Education training
C. 10 hours of Recovery/Wellness Support training
D. 16 hours of Ethical Responsibility

**Please submit appropriate paperwork verifying the training hours listed above.**

**Applicant's Agreement to the Recovery Code of Ethical Practice and Professional Conduct**

I have read the Current Recovery Support Ethics Code as listed on the MCB web site www.missouricb.com, MCB Ethics Code Link and agree to abide by this code:

Print Name Date

Signature Date

## AUTHORIZATION AND RELEASE

I hereby certify all of the information given herein is true and complete to the best of my knowledge and belief. I also authorize any relevant investigations, or the release of personal information to the Missouri Credentialing Board, its agents, or contractors pursuant to this application/renewal procedure. I understand falsification of any portion of this application/renewal will result in my being denied credentialing, or revocation of same upon discovery.

I further agree to hold the Missouri Credentialing Board and its Board Members, officers, agents, staff, peer evaluators and examiners, free from any civil liability for damages or complaints by reason of any action that is within the scope and arise out of the performance of their duties which they, or any of them, may take in connection with this application/renewal, any examination, the grades with respect to any examination, and/or the failure of the MCB to issue me said credential or renewal.

This Authorization and Release shall also apply to personal information requested by the Board at any time following credentialing in connection with any investigation concerning allegations that could lead to disciplinary action against me.

Print Name Date

Signature Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
**WORKER REGISTRATION**

**PLEASE TYPE OR PRINT CLEARLY**

## SECTION A: WORKER TYPE (CHECK ONE BOX ONLY)

☐ CHILD CARE WORKER ($9☐) ☐ PERSONAL CARE WORKER ($9.00) ☐ XX VOLUNTARY REGISTRANT

☐ ELDER CARE WORKER ($9.☐) ☐ RECIPIENT OF STATE OR FEDERAL FUNDS (☐.00) FOSTER PARENT (NO FEE)

## SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING

| LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| | | |

MAIDEN AND PRIOR NAMES USED

| SOCIAL SECURITY NUMBER *(ATTACH COPY OF SOCIAL SECURITY CARD)* | DATE OF BIRTH | GENDER | TELEPHONE NO. (OPTIONAL) |
|---|---|---|---|
| - - | / / | ☐ MALE ☐ FEMALE | ( ) |

## MAILING ADDRESS

| STREET ADDRESS OR POST OFFICE BOX | CITY | STATE | ZIP CODE | COUNTY |
|---|---|---|---|---|
| | | | | |

## HOME ADDRESS (if different than mailing address)

| STREET ADDRESS | CITY | STATE | ZIP CODE | COUNTY |
|---|---|---|---|---|
| | | | | |

## SECTION C: CURRENT EMPLOYER INFORMATION (IF APPLICABLE)

| EMPLOYER NAME | CONTACT PERSON | PHONE NUMBER |
|---|---|---|
| | | ( ) |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

## SECTION D: AUTHORIZATION TO RELEASE BACKGROUND SCREENING INFORMATION

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Futhermore, I authorized the Missouri Department of Health and Senior Services to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requestor of the FCSR for employment purposes only, as provided in 210.921, subsection 1 subdivision (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy in the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening determination.

**NOTICE:** The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to your designated bank account. I understand that my signature below authorized my Financial Institution to deduct this payment from my account. In the event that DHSS or its subcontractor, is unable to secure funds from your account or you provide insufficient or inaccurate information regarding your account, your obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

| SIGNATURE OF APPLICANT (REQUIRED IN INK) | DATE |
|---|---|
| ▶ | / / |

**IM**

***Submit this form with your application and a copy of your SS card. If your agency has ran a FCSR check within the last 30 days, you can submit the results with this form which may speed up the application process. By doing so, you give permission for your agency to share their FCSR results.***

MO

# Missouri Credentialing Board

**428 E. Capitol, 2nd Floor, Jefferson City, MO 65101**

# WORK/VOLUNTEER VERIFICATION FORM

An applicant is applying to the MCB for a Certified Reciprocal Peer Recovery Credential. Please complete this form and provide a copy to the applicant to include with their application.

Applicant's Name: _____

Supervisor's Name (Print):_____

Organization Name: _____

Address: _____

_____

Telephone: _____

E-mail: _____

Today's Date: _____

Within the last 10 years from the date listed above, please list the **composite total** number of hours the applicant spent working with substance use disorder clients in the following domains: **(Please list all hours worked as this form replaces any previous employment forms submitted with prior applications)**

**The formula for computing hours is to take the total number of months worked within the last 10 years and multiply that by 167 hours per month to get the total number of hours. Then divide that total number as appropriate into the 4 domains below.**

**Advocacy:** _____

**Mentoring/Education:** _____

**Recovery/Wellness Support:** _____

**Ethical Responsibility:** _____

Supervisor's Name (Printed): _____

Supervisor's Signature: _____

Date: _____

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## SUPERVISED PRACTICUM OF THE PERFORMANCE DOMAINS

INSTRUCTIONS: On this form, document only the number of hours the applicant has already completed performing each domain. A minimum of 25 total hours must be documented. Please complete this form and provide a copy to the applicant to include with their application.

**Applicant's Name(Print):**_____

Supervisor (Print):_____

Agency:_____

Total # Supervised Work Hours (Must be a minimum of 25 hours):_____

Please indicate on the domain lines below how many of the Total # Supervised Work Hours listed above were in each domain. The total listed on the line above should equal the sum total of the 4 domains:

**Advocacy:** _____

**Mentoring/Education:** _____

**Recovery/Wellness Support:** _____

**Ethical Responsibility:** _____

Supervisor's Name (Printed): _____

Supervisor's Signature: _____

Date: _____

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# PROFESSIONAL REFERENCE FORM

**The individual completing this form should be able to provide a professional reference for the applicant. This form can only be filled out by a CADC, CRADC, CRAADC, CCJP, CRPS, MAPS, RADC, RADC-P, CCDP, CCDP-D, LPC, LCSW, Licensed Psychologist, or a Director of a certified recovery support program. This form cannot be filled out by an immediate family member. Please complete the form and give a copy to the applicant to include with their application.**

I. Name of Applicant: _____
II. Name of Reference (Print):_____
III. Relationship to Applicant:_____
IV. Credential or License Held If Applicable:_____
V. Reference Phone Number:_____
VI. Reference Address:_____
VII. Reference Signature_____ Date:_____

Please describe the nature of your relationship with the applicant and describe why you believe the applicant is qualified to be a Certified Reciprocal Peer Recovery:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever known the applicant to operate in an unethical manner while performing duties related to the field of substance use disorders and if so, please describe the behavior?

_____
_____
_____
_____
_____

# DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (physician, psychologist, psychiatrist) to ensure that your board is able to provide the required exam accommodations. Submitted documentation must follow ADA guidelines in that psychological or psychiatric evaluations must have been conducted within the last **three years**. All medical/physical conditions require documentation of the treating physician's examination conducted within the previous **three months**.

**Professional Documentation:**

I have known _____ since _____/_____/_____ in my
Exam Candidate Date
capacity as a _____.
Professional Title

The candidate discussed with me the nature of the exam to be administered. It is my professional opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the special arrangements listed below:

Description of Disability:

_____
_____
_____
_____
_____
_____

Signed: _____ Title: _____

Printed Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ Email:_____

License Number: _____ Date: _____
(if applicable)

# REQUEST FOR SPECIAL ACCOMMODATIONS

If you have a disability that requires special testing accommodations, please complete this form and the Documentation of Disability-Related Needs and return it to your IC&RC member board for processing. The information you provide and any documentation regarding your disability and your need for accommodations in testing will be treated with strict confidentiality. Submitted documentation must follow ADA guidelines in that psychological or psychiatric evaluations must have been conducted within the last **three years**. All medical/physical conditions require documentation of the treating physician's examination conducted within the previous **three months**.

Preferred Exam Date: _____ Preferred Exam Location: _____

Name: _____

Home Address:_____

City/State/Zip: _____

Daytime Telephone Number: _____

Email: _____

**Special Accommodations:**

I request special accommodations for the following IC&RC ADC examination

Please provide (check all that apply):

_____☐ Special seating or other physical accommodations
_____☐ Reader
_____☐ Large print exam
_____☐ Extended testing time (time and a half)
_____☐ Distraction-free room
_____☐ Other special accommodations (please specify)

Comments:
_____
_____
_____
_____

Print Name: _____

Signature: _____

Date:_____