Missouri
Credentialing Board

(573) 616-2300 www.missouricb.com 428 E. Capitol, 3rd Floor
email: help@missouricb.com Jefferson City, MO 65101

Criteria for Certified Reciprocal Prevention Specialist (CRPS)

Certified Reciprocal Prevention Specialist

- Completion of Substance Abuse Prevention Specialist Training (SAPST)
- HS Diploma/HSE & 4000 hours prevention work experience within last 10 years **or**
- Bachelor Degree (Higher) & 2000 hours prevention work experience within last 10 years
- Degree must be from a college or university found in the US Dept. of Education's database of accredited schools. The database can be found at http://ope.ed.gov/accreditation.
- 120 Performing Hours of Supervised Practicum in the IC&RC prevention domains with a minimum of 10 performing hours in each domain
- 120 Total Contact Hours of Education relating to the IC&RC prevention domains. Within the 120 hours, there are some specific requirements including:
  - **6 contact hours of prevention ethics**
  - **24 contact hours of Alcohol, Tobacco, and Other Drug specific training**
  - **20 hours of the 120 hours must have been obtained in the 12 months prior to applying**
- Pass the IC&RC International Prevention Specialist Examination

CHECK LIST FOR CRPS APPLICATION

1. You have completely filled out the application.
2. You have signed the Prevention Code of Ethical Practice/Professional Conduct and Authorization & Release.
3. You have filled out the Family Care Safety Registry Worker Registration Form and included the form with your application. 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.
4. You have submitted the $335.00 with this application or have provided your credit card information on page 7 of this application. **Applications will not be reviewed until payment is received.**
5. The appropriate person has completed and signed the Prevention Professional Employment Verification Form and you have included the completed form with the application.
6. The appropriate High School/HSE or college transcripts were included.
7. The appropriate certificates of completion are attached documenting the total hours of education needed for the CRPS.
8. The supervised practicum form has been included by a MCB Qualified Prevention Supervisor. The form documents at least 120 total hours of practicum hours with at least a minimum of 10 hours in each of the performance domains.
9. If applicant does not hold the Missouri Prevention Specialist (MPS) credential, a copy of the certificate showing completion of the Substance Abuse Prevention Specialist Training (SAPST) must be 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 to the MCB, call the MCB.
11. If you took and passed the examination and you have not received correspondence from the MCB, check the Professional Search on the MCB web site 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.

DEFINITIONS

A. **CONTACT HOURS of EDUCATION/TRAINING** is defined as workshops, seminars, institutes, college/university courses, on-line or home study as approved by the MCB, and in-services. One (1) contact hour of education is equal to sixty (60) minutes of continuous instruction. 15 contact hours are given for each college credit. Therefore, a college course of three (3) credits is equal to forty-five (45) contact hours.

In order to be considered a valid training experience for the purpose of credentialing, all contact hours must be related to the knowledge and skill base associated with the prevention performance domains.

All education/training taking place outside the applicant's place of employment must be documented through proof of attendance including transcripts from an accredited college, letters and/or certificates of training completion. Supporting documentation in the form of brochures, flyers, syllabus, course description, etc. is also required to review content for acceptability.

All education/training taking place within the applicant's place of employment must be documented by title, date and length of presentation, as well as the name and title of presenter. The employee's supervisor who attests the training took place and the employee was a participant in the entire training must verify the training.

B. **APPLICABLE WORK EXPERIENCE** is defined as supervised work experience in prevention related positions with job duties that are specific to the prevention performance domains. Experience as a volunteer, intern, and/or payment of a stipend qualifies as employment if the same work is performed that a paid employee would perform.

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

Work experience must be verified by an employment verification form from the agency(s) in which the applicant has been employed.

C. **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. Applicants must complete a minimum of 10 hours performing each of the performance domains with a total supervised practicum of 120 hours.

The practicum hours must be signed by a MCB Qualified Prevention Supervisor.

D. PERFORMANCE DOMAINS DEFINITIONS: Refer to the PS Candidate Guide on the MCB web site at www.missouricb.com under the Education Box/Candidate Guide link.

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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 current application packet. If you are unsure, contact the MCB office.
2. The application must be typed or neatly printed**.**
3. If you do not already hold the Missouri Prevention Specialist Credential, you must submit a copy of the Substance Abuse Prevention Specialist Training (SAPST) completion certificate.
4. Please keep a copy of all materials submitted for your records.
5. FEES: The total CRPS Fee is $335.00. You may pay by check, money order, or by providing credit card information on page 7 of the application packet. **Applications will not be reviewed until payment is received.**
6. Please be advised that should your application be reviewed and additional information is requested, you will have 90 days to provide the requested information. Failure to do so will result in your application expiring without being approved.
7. All fees are non-refundable. If your application is denied or expires, fees will not be refunded.
8. If your application is denied, you may contact the MCB office staff for instructions on how to appeal the denial of your application.
9. All materials submitted to the MCB office become property of the MCB.
10. The applicant must currently reside and/or be employed 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.
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 us. Please <u>do not fax</u> or e-mail your application.**

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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 as well as a free study guide. In addition, you will receive information regarding IC&RC practice exams that can be purchased.
3. The CRPS credential is a reciprocal credential with other IC&RC member boards that offer the prevention 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 Prevention Specialist (CRPS)

Appropriate fee must be submitted with application.

MISSOURI CREDENTIALING BOARD
428 E. Capitol, 3rd 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: _____

Credit Card Zip Code: _____

THIS APPLICATION MUST BE TYPED OR PRINTED NEATLY
All Applications Become the Property of MCB

Please check if you are: ☐ New Applicant ☐ Upgrade Applicant

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: _____

BIRTH DATE: _____/_____/_____

Are you currently or have you been credentialed or licensed as a Prevention Professional by 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 **CONVICTED** of and/or **PLEAD GUILTY** to a felony (including SIS or SES)? ☐ 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 Children's Division 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.

Your Required Demographic Information Below (Please Type or Print Very Legibly)

Gender: ☐ Female; ☐ Male; ☐ Decline to State; ☐ Other: _____

Ethnicity: ☐ American Indian/Native Alaskan/Native American; ☐ Asian; ☐ Black/African American; ☐ Decline to State; ☐ Hispanic/Latino; ☐ Multi-Racial/Ethnic; ☐ Native Hawaiian/Pacific Islander ☐ White; ☐ Other: _____

Salary: ☐ $0-$14,999; ☐ $15,000-$24,999; ☐ $25,000-$34,999; ☐ $35,000-$44,999; ☐ $45,000-$54,999 ☐ $55,000-Over; ☐ Decline to State

Military Service: ☐ Never served in the military;
☐ Active duty for training in the Reserves or National Guard;
☐ On Active duty in the past, but not now for the Reserves or National Guard;
☐ Now on active duty;
☐ On active duty in the past, but not now;
☐ Veteran

Primary Language: ☐ English; ☐ Spanish; ☐ Chinese; ☐ Tagalog; ☐ Vietnamese; ☐ Arabic; ☐ French; ☐ Korean; ☐ Russian; ☐ German; ☐ Other: _____

Secondary Language: ☐ N/A; ☐ English; ☐ Spanish; ☐ Chinese; ☐ Tagalog; ☐ Vietnamese; ☐ Arabic; ☐ French; ☐ Korean; ☐ Russian; ☐ German; ☐ Other: _____

Highest Level of Education Completed: ☐ Associates Arts/Science Degree; ☐ Bachelor Arts/Science Degree; ☐ Doctorate; ☐ High School Diploma or HiSET; ☐ Some College Credit; ☐ No High School Diploma or HiSET; ☐ Vocational Certificate; ☐ Other: _____

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

TRAININGS/EDUCATIONAL HOURS

Following are the guidelines for educational hour requirements:

- 120 total hours
- 6 contact hours of prevention ethics
- 24 contact hours of Alcohol, Tobacco & Other Drug specific training
- 20 hours in last 12 months prior to applying

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

I have read the Current Prevention Code of Ethical Practice and Professional Conduct as listed on the MCB web site www.missouricb.com, MCB Ethics Code Link and agree to abide by this code:

Printed 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.

Printed Name Date

Signature Date

Be sure to print, sign and date in all places on this page!

Missouri Credentialing Board

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PREVENTION PROFESSIONAL EMPLOYMENT VERIFICATION

An applicant is applying to the Missouri Credentialing Board for certification as a Certified Reciprocal Prevention Specialist. Please complete this form and provide a copy to the applicant to include with their application.

Applicant's Name: _____

Supervisor's Name (Print):_____

Agency: _____

Address: _____

_____

Telephone: _____

Email: _____

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 6 domains below.

Planning and Evaluation: _____
Prevention Education & Service Delivery _____
Communication: _____
Community Organization: _____
Public Policy and Environmental Change: _____
Professional Growth and Responsibility: _____

Supervisor's Name (Printed): _____

Supervisor's Signature: _____

Date: _____

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 120 total hours must be documented with a minimum of 10 hours in each performance domain.

This document must be signed by either a CRPS or a MAPS who has attended the ACT Missouri sponsored Prevention Supervision Course.

Applicant's Name(Print):_____

MCB Qualified Supervisor (Print):_____

Agency:_____ Prevention Supervision Number:_____

Total # Supervised Work Hours (Must be a minimum of 120 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 6 domains (Must be a minimum of 10 hours listed for each domain):

Planning and Evaluation:	_____ Hours
Prevention Education & Service Delivery	_____ Hours
Communication:	_____ Hours
Community Organization:	_____ Hours
Public Policy and Environmental Change:	_____ Hours
Professional Growth and Responsibility:	_____ Hours

MCB Qualified Supervisor's Signature:_____ Today's Date: _____

Please complete this form and provide a copy to the applicant to include with their application.

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:_____

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 ($9.0☐ 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
	/ /

Submit this form with your application and a copy of your SS card. If your agency has run an FCSR check within the last 30 days, you may 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.