

TO BE COMPLETED BY DSAMH	Date application reviewed: _____
Name: _____ <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Referred to Supervisor? <input type="checkbox"/> YES <input type="checkbox"/> NO

Please type or print clearly. All sections must be completed for the application to be processed.

The information you provide on this page will be shared with designated person(s) from the Division of Substance Abuse and Mental Health for the purpose of enrollment to the Certified Peer Support Specialist (CPSS) Training.

DEMOGRAPHIC INFORMATION				
Applicant's Name	Last	First	Middle Initial	Daytime Telephone Number
Mailing Address				Phone Number
City	State	Zip Code		County
Email Address				Highest level of education completed
SELF IDENTIFYING				
Ethnicity (<i>Optional</i>)				
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____				
"Consumer" means: A person, who has applied, is eligible for or has received mental health and/or substance use services. (currently or in the past) <input type="checkbox"/> I agree that I am a "consumer" based on the definition as stated and I am 18 years of age or older.				
Volunteer Organization/Employer Name (if applicable)			<input type="checkbox"/> Please check box if you are a veteran	
*Please provide at least two letters of reference (personal, volunteer or employer), attach to the application.				
Confidentiality Statement: The information provided will be treated as confidential information. It will only be available to authorized DSAMH Staff, for consideration of the class(es) it is intended for.				
The following questions can be answered on a separate piece of paper and attached to this application. (please type responses)				
1. Provide a brief history of your recovery journey 2. Describe what you are doing to remain in recovery 3. In what ways have you assisted others using your own experience as an example				
Please sign and date this document to indicate your understanding of each of the following:				
➤ If I am chosen as a training participant, I understand that I am responsible for my own funding, such as and not limited to: registration fee, travel, hotel accommodations, and meals unless otherwise specified. ➤ I understand that training slots are limited and therefore submission of this application does not guarantee admission. ➤ I understand that I must successfully pass a written exam within two months of completing the 40 hours of training. ➤ I understand that as a certified peer support specialist it does not guarantee employment.				
EQUAL OPPORTUNITY STATEMENT				
<i>The division of Substance Abuse and Mental Health provides equal opportunity for all applicants regardless of race, color, creed, religion, national origin, sexual orientation, veteran status, gender, disability status or age.</i>				
SIGNATURE			DATE	

Mail, E-mail or Fax your completed application, letter(s) of recommendation and other attachments as specified to:

Division of Substance Abuse and Mental Health (DSAMH)
 Attn: Carmen Lloyd
 195 North 1950 West
 Salt Lake City, UT 84116
 Email: cklloyd@utah.gov

FAX: 801-538-4696
 PHONE: 801-538-3939
 DSAMH (9/2014)