



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH
OFFICE OF CONSUMER AFFAIRS
CORDELL HULL BUILDING, THIRD FLOOR
425 FIFTH AVENUE, NORTH
NASHVILLE, TENNESSEE 37243

TENNESSEE CERTIFIED PEER SPECIALIST CERTIFICATION RENEWAL APPLICATION

Please Print

Renewal Application PART I – Applicant Contact Information and Verification of Status

Full Name _____

Certification Number: _____ Certification Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: _____

Email: _____

Circle:

- I have successfully completed 15 hours of recognized continuing education. Yes No
- I certify that I have not committed any violations to the TCPS Code of Ethics; in addition I have no reports of violation to the TCPS Code of Ethics. Yes No

If you circled "No" on any of the statements above, please explain: _____

Renewal Application PART II – Verification of Continuing Education

Twenty (15) hours of continuing education are required annually to maintain active certification and must be earned within the annual certification period. Please refer to Section VI of the TCPS Handbook for Continuing Education requirements.

List the title and date of the training, the sponsoring organization, and the number of hours for each training attended. Submit this application with a copy of the Certificate of Attendance or Completion for each training listed.

1)	_____	_____
	Title of the Training	Sponsor
	_____	_____
	Number of Training Hours	Training Date
2)	_____	_____
	Title of the Training	Sponsor
	_____	_____
	Number of Training Hours	Training Date
3)	_____	_____
	Title of the Training	Sponsor
	_____	_____
	Number of Training Hours	Training Date
4)	_____	_____
	Title of the Training	Sponsor
	_____	_____
	Number of Training Hours	Training Date

Total Number of Hours _____

My signature below affirms that all of the information attached to and contained in this certification renewal application is true and correct to the best of my knowledge. I understand that knowingly providing false information shall be grounds for termination of certification.

Signature of Applicant

Date

Note: The Certification Renewal Application and all required documentation must be submitted at least 45 calendar days prior to the end of the current certification period.

Currently working as a TCPS
If no, omit part III of the application.

Yes

No

Renewal Application PART III – Employment Summary – Completed by the supervising mental health professional and faxed to the Office of Consumer Affairs at 1-615-253-3920. My be omitted if not currently working as a TCPS.

A Tennessee Certified Peer Specialist (TCPS) who is employed must be under the general supervision of a mental health professional mental health professional in accordance with acceptable guidelines and standards of practice as defined by the State. Provide the following information regarding the agency staff that provides direct supervision:

Supervisor's Name: _____

Credentials: _____ Position: _____

Agency: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (____) _____ - _____ ext. _____

Email: _____

TCPS's Name: _____

TCPS's job title within the agency: _____

Full-time / part-time (circle one) Number of hours worked per week: _____

Certification number: _____ Certification Date: _____

- | | Circle: | |
|---|---------|----|
| • The applicant is employed by this agency. | Yes | No |
| • The applicant is under my general supervision. | Yes | No |
| • The applicant performs duties specified in the TCPS Scope of Activities. | Yes | No |
| • The applicant has successfully completed 20 hours of recognized continuing education. | Yes | No |
| • I certify that I have not committed any violations to the TCPS Code of Ethics; in addition I have had no reports of violation to the TCPS Code of Ethics. | Yes | No |
| • | | |

If you circled "No" on any of the statements above, please explain: _____

I verify that all of the information contained in this document is true and correct to the best of my knowledge and that the above-named applicant is employed by this agency.

Signature of Supervising Mental Health Professional

Date

Do Not Write Below This Line

Internal TDMH OCA Use Only

Date received: _____

Date reviewed: _____ Approved _____ Not-approved _____

Date letter of findings mailed to applicant: _____

Date information recorded in database: _____

Notes: _____

Processed by: _____