

**VERIFICATION OF EMPLOYMENT
FOR PEER RECOVERY SUPPORT SPECIALIST CERTIFICATION**

****Due within 6 months of certification date** ** Required for renewal****

Applicant Name: _____

PRINT NAME CLEARLY

Signature of Applicant: _____ Date: _____

TO BE COMPLETED BY PERSON VERIFYING EMPLOYMENT (Please Print)

****Qualifying Agency must be certified by and/or contracted with ODMHSAS.****

Agency Name: _____

Agency ADDRESS with ZIP _____

Agency NPI#: _____

Applicant's Hire/Volunteer Date: _____

Name of person verifying: _____

Title/Position of person verifying: _____

Agency contact phone#: _____ Agency contact email: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT:

Signature of Supervisor verifying: _____ Date _____