

APPLICATION INSTRUCTIONS

The initial application is a brief sketch of the professional's qualifications. This is meant to be an assessment for review purposes. This application is a recording and compilation of documents demonstrating competency in the knowledge and skills specifically related to the domains of the Certified Recovery Support Specialist – Employment Endorsement (CRSS-E). This process includes validation from employers, supervisors, and instructors.

1. Application forms must be neatly printed or typewritten.
2. Clip your materials to keep them together. Do not place your application materials in binders, folders, report covers, etc.
3. Your check or money order should be made payable to ICB. All fees (where applicable) are non-refundable. (**No** refunds will be given.)
4. Make a photocopy of your entire completed application including all attachments for your records. Send the original copy of the application and copies of all other documents.

Faxed applications will not be accepted.

5. Applications will not be approved until all sections are completed and signed where required. If there are problems with your application materials, you will receive written notification.
6. It is the applicant's responsibility to notify ICB in writing of any changes to name, work/home address and work/home telephone numbers.
7. Applications not completed after one year will be closed and the applicant will need to reapply.
8. ICB reserves the right to request further information from employers and other persons listed on the application forms.
9. Send completed application to:
ICB, Inc.
401 East Sangamon Avenue
Springfield, IL 62702

**CRSS – EMPLOYMENT ENDORSEMENT (CRSS-E)
APPLICATION**

PLEASE PRINT OR TYPE

Name _____ / / _____
 Last First Middle Date of Birth

Home Address _____ Male Female

City _____ State _____ Zip Code _____

County _____ Telephone ____/____-____ Fax ____/____-____

Email address at home _____ @ _____

Current Employer _____

Employer Address _____

City _____ State _____ Zip Code _____

County _____ Telephone ____/____-____ Fax ____/____-____

Email address at work _____ @ _____

I would like correspondence sent to: Home Address Work Address

Please check one selection from each of the following areas:

Ethnic Origin

- Caucasian
- Black/African-American
- Asian or Pacific Islander
- Other _____

Highest Education Level Completed

- High School Diploma or GED
- Vocational Certificate
- Associate of Arts/Sciences
- Bachelor of Arts/Sciences
- Master of Arts/Sciences
- Doctorate

Primary Work Setting

- | | | |
|---|---|--|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Inpatient Treatment | <input type="checkbox"/> Department of Corrections |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Private Practice | <input type="checkbox"/> College/University |
| <input type="checkbox"/> Residential | <input type="checkbox"/> Outpatient Treatment | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Intensive Outpatient | <input type="checkbox"/> Case Management & Referral | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Medical/Hospital |
| <input type="checkbox"/> MISA | <input type="checkbox"/> Elementary/High School | <input type="checkbox"/> Other _____ |

Primary Population Served

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Adults | <input type="checkbox"/> Geriatrics |
| <input type="checkbox"/> Adolescents | <input type="checkbox"/> Mixed |
| <input type="checkbox"/> Children | <input type="checkbox"/> Nursing |

Primary Profession

- | | |
|--|--|
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Occupational <input type="checkbox"/> Therapy |
| <input type="checkbox"/> Peer Recovery | |

Application Number _____

All answers are correct to the best of my knowledge. I authorize any educational institution, employer, or other body having knowledge of my professional or academic status, to release information to ICB.

Signature of Applicant

_____/_____/_____
Date

Please Note: The Illinois Certification Board, Inc. may request further information with regards to the documentation presented in this application. This information is not available to others outside the credentialing process without the written consent of the applicant. This information will be used strictly to evaluate professional competence of the applicant and **WILL BE KEPT CONFIDENTIAL BY ICB.**

WORK EXPERIENCE FORM

I hereby attest that the applicant is working and/or volunteering in a position where a minimum of 51% of his/her time is spent providing peer recovery support services specific to IPS Supported Employment.

The applicant minimally has primary responsibility for providing peer recovery support services specific to IPS employment supports for an individual and/or group of individuals with mental health conditions; contributing to treatment plans and documenting client progress; or provides peer recovery support services within an organization whose IPS program is highly integrated with its peer recovery program.

Signature of Supervisor

Date

Signature of Applicant

Date

To determine eligibility of current and previous employment/volunteer work, the following must apply to and be clearly documented by applicant:

You must be currently employed or volunteer in a recovery support specialist position to be eligible for the Certified Recovery Support Specialist – Employment Endorsement (CRSS-E).

Acceptable employment is one in which the applicant is working in a position where a minimum of 51% of his/her time is spent providing peer recovery support services specific to IPS Supported Employment.

_____ I am a Certified Recovery Support Specialist.

(Attach a copy of your current certification)

You must currently hold the Certified Recovery Support Services credential, and be in good standing with the Illinois Certification Board, to be eligible for the CRSS-E.

Application Number _____

BE SURE TO ATTACH A JOB DESCRIPTION FOR YOUR CURRENT POSITION. Job description must be on agency letterhead and dated and signed by applicant and supervisor. All relevant former employment or internship experience must be verified by job descriptions from employers.

Position/title _____

Date Employed/Interned:

From _____ to _____ hrs. of work per week _____
mo./day/yr. mo./day/yr.

Place of Employment/Internship: _____

Immediate Supervisor: _____

Title _____ Telephone Number (____) _____

Position/title _____

Date Employed/Interned:

From _____ to _____ hrs. of work per week _____
mo./day/yr. mo./day/yr.

Place of Employment/Internship: _____

Immediate Supervisor Signature: _____

Title _____ Telephone Number (____) _____

SUPERVISED PRACTICAL EXPERIENCE

To the Supervisor: Please complete this form indicating the applicant's supervised practical training. This form is not intended to document the applicant's total number of hours worked, but rather the hours of supervision you have provided the applicant. PLEASE RETURN THIS FORM DIRECTLY TO ICB, 401 East Sangamon Avenue, Springfield, IL 62702.

Applicant's Last Name	First Name	Middle Name
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I hereby attest to the fact that I have provided the applicant supervision for the number of hours noted below.

The applicant has been provided supervision while performing the tasks specific to the Certified Recovery Support Specialist – Employment Endorsement (CRSS-E) performance domains.

- 1 Staffing
- 2 Organization
- 3 Services

All of these hours have been spent observing (directly or indirectly) the applicant in the performance of Certified Recovery Support Specialist – Employment services and receiving individual or group feedback on the performance of such services.

Total number of hours of supervision I have provided the applicant _____ (minimum 25)

Supervisor's Signature

_____/_____/_____
Date

Supervisor's Printed Name

Supervisor's Title

Supervisor's Employer

_____/_____/_____
Employer Phone Number

Address

City

State

Zip Code

ASSURANCE AND RELEASE

The Illinois Certification Board, Inc. (ICB) may request further information with regards to the documentation I have presented in this application. This information is not available to others outside the registration process without written consent of the applicant.

I give my permission for ICB and staff to investigate my background as it relates to information contained in this application for CRSS-E endorsement. I understand that intentionally false or misleading statements, or intentional omissions, shall result in denial or revocation of registration.

I consent to the release of information contained in my application file and other pertinent data submitted to, or collected by ICB, to officers, members, and staff of the afore-mentioned board.

I further agree to hold ICB, its officers, board members, employees and examiners free from civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which they may take in connection with this application and/or the failure of ICB to issue the registration. In the event my certification is sanctioned, terminated or suspended, I agree to surrender my Certified Recovery Support Specialist – Employment Endorsement (CRSS-E).

I further certify that my CRSS-E and status is public knowledge.

I hereby affirm that the information provided on this form is correct and that I believe I am qualified for the endorsement for which I am applying.

<hr/> Signature of Applicant	<hr/> / / Date
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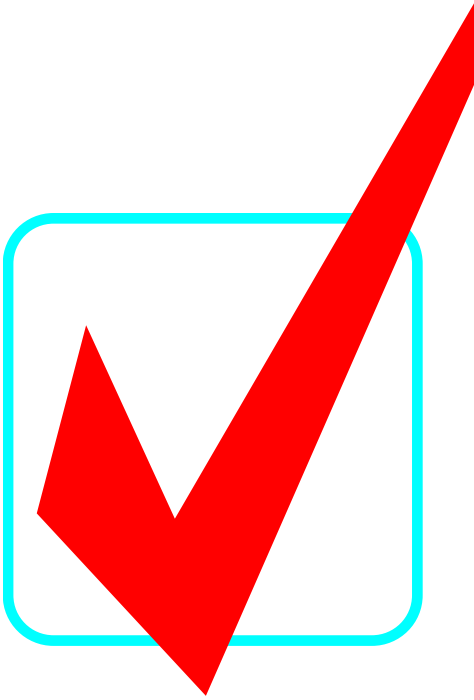
**CODE OF ETHICS REAFFIRMATION
FOR CRSS-E ENDORSEMENT**

I have read and abide by the Code of Ethics for the Certified Recovery Support Specialist credential.

Signature of Applicant _____ Date _____

Signature of Notary _____ Date _____

Notary Stamp _____



Certified Recovery Support Specialist – Employment Endorsement (CRSS-E) Check List

The following should be in your Application for the CRSS-E Endorsement

- _____ General Information Sheet.....page 2-3
- _____ Work Experience Form....page 4-5
(Attach Job Description)
- _____ Supervised Practical Experience....page 6
- _____ Assurance and Release (Signed and dated).... page 7
- _____ Code of Ethics Reaffirmation (Signed, dated & notarized)..... page 8
- _____ Dartmouth IPS Supported Employment Practitioner Skills Training (Attach documentation of completion)

Mail all application materials to:

Illinois Certification Board, Inc.
401 East Sangamon Avenue
Springfield, IL 62702

Applications will not be accepted by fax.