



CPS Practicum Application

INTERN INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

E-mail: _____

How did you hear about the Certified Peer Specialist (CPS) Practicum?

Are you a Veteran? () Yes () No

EDUCATION

Highest level of education: _____

Any other education or training you've received: _____

EMPLOYMENT

Please attach a resume.

Please check which best describes your current employment status:

____ Volunteer ____ Retired ____ Student ____ Unemployed

Other, please explain _____

EMPLOYMENT CONTINUED

Within the last three years, have you had at least 12 months (it does not need to be consecutive) of full- or part-time or voluntary work experience? () Yes () No
If yes, please give the following:

- The date of this employment or volunteer experience _____
- The name of the employer(s) _____

- Your responsibilities _____

- The number of hours volunteered or worked per week _____

SKILLS OR QUALIFICATIONS

Summarize skills and qualifications you have acquired from employment, previous volunteer work or other activities, including hobbies or sports.

OTHER WORK OR COMMUNITY EXPERIENCE

Summarize your previous work or community experience.

ESSAY QUESTION

Please choose **one** of the three statements below and write a short essay (minimum 300 words):

- “Nothing about us without us” is the motto of the consumer/survivor movement. What does this phrase mean to you, and how will it influence your practice as a Certified Peer Specialist?
- Please discuss how someone helped you in your recovery journey to discover recovery principles, such as self-help, empowerment, and self-advocacy. How will this experience influence your practice as a Certified Peer Specialist?

- Certified Peer Specialists have a variety of lived experiences. How will you use your personal experience in your practice as a Certified Peer Specialist?

REFERENCES

Please list two non-family references that we might contact:

- a. _____ Phone: _____
- b. _____ Phone: _____

SIGNATURE

Name: _____
(Please Print)

Signature: _____ Date: _____

Please return this application to:

Mental Health Partnerships
833 Chestnut Street, Suite 1100
Philadelphia, PA 19107
Attn: Denise Sherman

For more information about Mental Health Partnerships, please call 267-507-3843.or
email dsherman@mhphope.org