

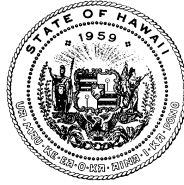


AMHD

ADULT MENTAL HEALTH DIVISION

CERTIFIED PEER SPECIALIST TRAINING

Professional Reference Form



STATE OF HAWAII
ADULT MENTAL HEALTH DIVISION
OFFICE OF CONSUMER AFFAIRS
P.O. BOX 3378
HONOLULU, HI 96801

HAWAII CERTIFIED PEER SPECIALIST PROFESSIONAL REFERENCE

The applicant named below is completing an application to enroll in AMHD's Peer Specialist training/internship program. All applicants must submit three professional references of support in order to complete the application process. You have been chosen by the applicant to provide a reference for this purpose. Once the professional reference is completed, place the form in an envelope, seal the envelope, sign the seal of the envelope with your signature, and return the envelope to the applicant so it can be submitted with the application. If you have questions, please contact the Coordinator of Hawaii's Peer Specialist Certification Program at (808) 586-4688.

Applicant's name: _____

1) Please describe your knowledge of the applicant's work in the role of a Peer Specialist:

2) Please describe the nature of your professional relationship with the applicant:

Note: A Professional Reference cannot be a family member.

3) Please describe the strengths and any potential weaknesses of the applicant and his or her ability to provide services as a Peer Specialist:

Reference Contact Information
(Please Print/Type)

Name: _____

Agency: _____

Address: _____

City, State, ZIP: _____

Email: _____

Work Phone: _____

My signature below affirms that all of the information contained in this document is true, and that I support this applicant without reservation.

Signature of Reference

Date