MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
DIRECTOR'S PREVENTION VERIFICATION OF STAFF CREDENTIALS

Staff Name:_____ Position/Title:_____

Program Name:_____ Requested Effective Date:_____

I. Substance Abuse Prevention Certification- Must qualify for A, B or C

A) Has one of the following Michigan specific or International Certification & Reciprocity Consortium (IC&RC) credentials in good standing:
- □ Certified Prevention Specialist – Michigan (CPS-M)
- □ Certified Prevention Specialist – IC&RC (CPS-R)
- □ Certified Prevention Consultant – Michigan (CPC-M)
- □ Certified Prevention Consultant- IC&RC (CPC-R)
- □ Certified Criminal Justice Professional (CCJP-R)
- □ Approved Alternative Certification _____

OR

B) Has a Registered Development plan and is timely in its implementation
Type of Registered Development Plan _____
Expiration Date of Plan_____

OR

C) □ Specially Focused Staff delivering service to general / universal populations (not required to be certified but works under certified supervisor)

Enter name and certification of Supervisor_____
_____

□ Specially Focused Staff delivering service to high risk populations such as selective or indicated (On another sheet of paper describe what criteria was used to verify level of competence. Additionally, they must work under a certified supervisor)

Enter name and certification of Supervisor_____
_____

II. Communicable Disease Training

Level I Communicable Disease Training Requirements Completed on _____ (attach verification), **Or** Will be completed by (within 6 months of hire)_____

Application must be submitted and approved prior to the provision of direct service, or services may not be reimbursed. Documentation must be submitted for all items checked above.

Required Documentation to submit:

- □ Resume
- □ Sudpds/Registration Request
- □ Certification
- □ Development Plan
- □ Communicable Diseases Training proof

Application Includes:

- □ Filled in Sections I. and II.
- □ Required Signatures

The undersigned attests to the personal possession of, and the authenticity and validity of the above described credential or equivalence and training.

_____ _____

Staff Member's Signature Date

The undersigned attests that the above described credential or equivalent, and training, has been verified as being possessed and in good standing by the staff person named above. The program has completed all MCOSA Staff Qualification and Credentialing requirements and has this information available as requested.

_____

PRINT Program Director's Name

_____ _____

Program Director's Signature Date

MCOSA Use Only

Initial Information Complete: ☐ Yes ☐ No
Additional Information Requested:_____
Date additional information received:_____

Directors Verification: ☐ Approved ☐ Denied

Authorization Effective Date:_____

_____ _____

MCOSA Authorization Signature Date