

# VERIFICATION OF EMPLOYMENT

FOR PEER RECOVER SUPPORT SPECIALIST CERTIFICATION

Applicant Name: \_\_\_\_\_  
PRINT NAME CLEARLY

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

---

***TO BE COMPLETED BY PERSON VERIFYING EMPLOYMENT (Please Print)***

Qualifying Agency must be an ODMHSAS Agency or have a contract with ODMHSAS/OK Health Care Authority to provide services.

---

Agency Name: \_\_\_\_\_

Agency NPI# \_\_\_\_\_

Agency ADDRESS with Zip Code: \_\_\_\_\_

Applicant's Hire/Volunteer Date: \_\_\_\_\_

Name of person verifying: \_\_\_\_\_

Title/Position of person verifying: \_\_\_\_\_

Agency's contact email address: \_\_\_\_\_

Agency's contact phone# \_\_\_\_\_

*I verify that the above information is true and correct:*

Signature of person verifying: \_\_\_\_\_ Date: \_\_\_\_\_

*After agency completes this Verification of Employment form please fax with Renewal Summary form to 405-366-2304 or email to [Ramona.Gregory@odmhsas.org](mailto:Ramona.Gregory@odmhsas.org)*