Psychiatric Rehabilitation Association

Growing and Training the Recovery Workforce

CPRP/CFRP Recertification Form

Please complete the fields below, then return to PRA via email (certs@psychrehabassociation.org) or fax (703-506-3266), or mail (7918 Jones Branch Drive Suite 300, McLean, VA 22102) for processing.

First Name:____________________________________ Last Name: ____________________________________

PRA ID Number: ____________________________ Email Address: ____________________________________

Please select the credential you are recertifying: **CPRP** **CFRP**

	SELECT YES OR NO	
Have you completed a total of at least 45 contact hours of applicable continuing education and training?	YES	NO
Are at least half (22.5) of these hours from a PRA Approved Provider of Continuing Education? *If half of your hours are not from a PRA Approved Provider, please submit this form, and PRA will contact you for further instructions.*	YES	NO
Have you completed at least 4 contact hours SPECIFIC to Ethics in the Helping Professions?	YES	NO
In the PAST 3 years, have you been denied another professional license or certification?	YES	NO
In the PAST 3 years, have you been subject to any sanction or revocation by a licensing or credentialing body?	YES	NO
Are there any pending complaints against you regarding your work in mental health?	YES	NO
Are you currently involved in any activity that may be considered a felony, and/or are you under any probation or parole for such activity?	YES	NO

If you have answered YES to any of the past 4 items, please provide a written explanation below:

Recertification candidates are required to be familiar with the current PRA Code of Ethics (found at http://bit.ly/PRACodeOfEthics) and are encouraged to reference it regularly (PLEASE NOTE: The PRA Code of Ethics was updated in May 2018). Do you agree to abide by the PRA Code of Ethics?	YES	NO

	SELECT YES OR NO	
I agree to abide by the laws and statutes of the legal jurisdiction(s) in which I will practice:	YES	NO
I understand that Recertification application fees are NON-REFUNDABLE and NON-TRANSFERABLE.:	YES	NO
I understand that, unless I have otherwise specified in writing to PRA, my contact information, including name, mailing address and email, may be provided to state and local chapters/affiliates of PRA to provide me with information on upcoming events that may benefit my professional development.:	YES	NO
I understand that PRA will maintain a directory of certificants that will include my name, city, state/province and phone number (all contact information will be related to place of employment).:	YES	NO
Are you completing this application on behalf of SOMEONE ELSE?	YES	NO

If Yes, indicate your name and relationship to the certificant:

First Name:________________________ Last Name: ________________________

Relationship: ____

Confirmation: with my signature below, I certify that I understand the requirements of recertification, and that the information provided above is accurate and complete.

Full Name of Recertifying Individual: ____

Signature:____ Date: ____________________

Fees and Deadlines

Fee dates and deadlines: Early (January 1 - March 31), Regular (April 1 - September 30), Late (October 1 - December 31)

Please select a fee option below. PRA will charge the appropriate fee based on the postmark date (if mailed) or date received (if emailed or faxed). If you are select Current PRA Member in error, PRA will contact you about either paying membership dues or paying the nonmember rate ***before processing your recertification.***

Current PRA Member ($129 early, $145 regular, $195 late)

PRA Non-member ($249 early, $265 regular, $315 late)

Membership/Renewal + Recertification* ($254 early, $270 regular, $320 late)

*If you select Membership/Renewal + Recertification, PRA will ONLY charge membership IF you aren't a current member, or are expiring within six (6) months. If your membership is current, PRA will only charge the Current PRA Member rate. If you send a check, PRA will add one year to your membership expiration date.

Payment Method (Select): Check (Payable to PRA) Credit: VISA MasterCard Discover AmericanExpress

Name on Card: ________________________________

Card Number: ________________________________ Expiration Date (MM/YY):_______/_______

Billing Address:

Street and Unit:________________________________ City: ____________________

State/Province:______________ Zip/Postal Code:__________ Country: ____________________

CC Payment Authorization: *I authorize PRA to charge my card based on the selected option and calculated fee as indicated above.*

Signature:____ Date: ____________________