



Peer Support Specialist Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Peer Counseling Experience for Non-Trainee

Use a separate form for each supervisor verifying your supervision and peer services experience for each practice setting. This form may be duplicated. Fill out Section one and forward to the approved supervisor for completion.

Peers can meet the experience requirements in one of 3 ways:

1. Obtain 1,000 hours as a Peer Specialist Trainee under an approved supervisor (please use the other experience hours form for Trainee experience);
2. Verify 1,000 hours worked or volunteered as a peer prior to July 1, 2025; or
3. Hold a credential for 1 year as a Registered Agency Affiliated Counselor working as a peer counselor.

Please use this form for the second and third options above for non-trainee peer experience.

1. Applicant (Print Clearly)						
Name: Last		First		Middle	Birth Date (mm/dd/yyyy)	
Address:						
City:		State:		Zip Code:		
2. Supervised Peer Experience						
Applicants must have a minimum of 1,000 hours of experience after completing the peer training course . Please complete the actual months in the space provided below.						
Months of Supervision	From: mm	dd	yyyy	To: mm	dd	yyyy
Total hours worked as a peer specialist or peer counselor:						

Choose only one option below to verify the experience of the applicant above.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

☐ **Option A:** Peer experience obtained as a Registered Agency Affiliated Counselor working as a peer counselor.

The applicant has worked for at least 1 year as an AAC peer counselor after completing the HCA Peer Counselor Training. This experience needs to be verified by a Behavioral Health Provider or Employer.

Credential Number (if applicable)

First Issuance Date

Approved Agency Name

Agency Representative Name

Telephone Number

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I am authorized by the approved agency to verify their employment as a registered Agency Affiliated Counselor working as a peer counselor for the agency listed above.

Agency Representative Signature: _____ Date: _____

☐ **Option B:** Peer Counselor experience obtained prior to July 1, 2025, without a DOH credential.

The experience of working or volunteering as a peer counselor after completing the HCA Certified Peer Counselor Training. This experience can be verified by a Behavioral Health Provider or an employer that can confirm the applicant obtained at least 1,000 hours of experience as a peer counselor.

I am a: ☐ Behavioral Health Provider ☐ Employer

Supervisor or Employer Name

Current Phone

Credential Number (if applicable)

First Issuance Date (if applicable)

Agency/Organization Name

Current Street Address

City

State

Zip Code

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I meet or exceed the requirements in [WAC 246-929-170](#) to be an approved supervisor for peer specialist trainees. Option B also allows an employer to verify their work as a peer counselor prior to July 1, 2025.

Employer or Provider Signature: _____ Date: _____

Please provide a separate form for each supervisor.