RECERTIFICATION QUESTIONS FOR
DISASTER RESPONSE CRISIS COUNSELOR

1) Will you have completed the required 12 (CEUs) continuing education units by the date your DRCC Certification expires? Please circle one:

   yes  no

2) Are you currently engaged in the illegal use of controlled dangerous substances? “Currently” is defined as “within the last two years.” Note: Individuals answering “yes” to this question will receive follow-up correspondence directly from our office. Please circle one:

   yes  no

   If “yes”, please provide a detailed description.

3) Do you have a medical condition, or use chemical substances which in anyway impair or limit your ability to practice your profession? Note: Individuals answering “yes” to this question will receive follow-up correspondence directly from our office. Please circle one:

   yes  no

   If “yes”, please provide a detailed description of your limitation(s).

4) Since your DRCC Certification have you been convicted of any crime or offense? (Minor traffic offenses, such as speeding or parking need not be provided, but Motor Vehicle offenses such as driving while impaired or intoxicated must be disclosed.) Please circle one:

   yes  no

   If “yes”, please provide a detailed description of your offense.

   **Continued on other side**
5) Since your DRCC Certification have you been denied licensing, certification or any other credential?
   Please circle one:

   yes            no

   If “yes”, please provide a detailed description.

6) Since your DRCC Certification has any action been taken or is any action now pending against your professional license, or have you been permitted to surrender or otherwise relinquish your license to avoid inquiry, investigation or action by any other licensing authority?
   Please circle one:

   yes            no

   If “yes”, please provide a detailed description of your violation.

If more space is needed to complete the information required, please attach additional pages.

If further information is required, you will be contacted by the Mental Health Association in New Jersey.

I understand that by signing this form, I am certifying that all the information is true and complete to the best of my knowledge and further acknowledge that if the above information is willfully false, I am subject to disciplinary sanction including certification suspension and/or revocation.

_______________________________________________       _________________________________________________
signature     date         please legibly print name here