



WGP Warriors Against Addiction

P.O. Box 593 | Berlin, MD 21811

wgpwarriors2021@gmail.com

Name: _____

Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

SSN: _____ Date of Birth: _____ Sober Date: _____

Main Phone: _____ Email: _____

If WGP Warriors Against Addiction need to contact you, do you prefer () Phone () Email

Are you employed? () Yes () No Full-time Part-time

What is your usual work schedule? _____

Have you previously attended any classes offered by Maryland Addiction Professional Certification Board (MABPCB)? () Yes () No

In a few sentences, please explain why you are interested in pursuing this certification?

I hereby attest that the information presented in this application is true to the best of my knowledge. I further understand that submitting falsified information or violating the MABPCB Principle and Guidelines for Certified Peer Recovery Specialists will rescind and nullify this application.

Applicant's Signature

Date

WGP Signature

Date