



CERTIFIED RESIDENCE APPLICATION

Section 1 – Residence Information

Residence/Applicant/Organization/DBA name:

Type of organization: _____ If other, please specify:

Residence/Applicant billing address:

City: _____ State: Florida Zip: _____

Website address: _____

Office phone number: _____

How many residences do you have? _____

Do you own or operate a licensed drug & alcohol or mental health program/facility? _____

If yes, please list the name of the licensed program/facility:

Are you willing to participate in SCRRA activities? _____

Have you read and understood the Certified Residence requirements? _____

Section II – Contact Information

Principal business contact for this residence:

Name: _____ Position/Title or duties: _____

Phone number: _____ Email address: _____

Manager, senior resident or responsible person for this residence:

Name: _____ Position, title or duties: _____

Phone: _____ Email: _____

Contact information to appear on SCRRA website member page?

Name: _____ Phone: _____

Email: _____

**Use Separate sheet for additional management*

Section III – Training

Has someone active in management of recovery residence(s) completed additional training? _____

Please describe: _____

Job title, organizational role or duties: _____

Has someone active in the operation or peer support for this residence(s) completed additional training? _____

Please describe: _____

Job title, organizational role or duties: _____

Section IV – Applicant affidavit and signature

Are you willing to submit to Random Drug and Alcohol Screening?

Are you willing to submit to a Level III background check?_____

I hereby attest that the above information is true and complete, and that I am authorized to execute this application on behalf of the applicant. Applicant hereby requests for Certification of Residence for SCRRA.

Signature: _____ Date:_____