Wellness Recovery Action Plan®

WRAP®

Application Form

Name: (First) _____ (Middle) _____ (Last) _____

Cell Phone Number: (____) _____-_____

Alt. Phone Number: (____) _____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Company/Affiliation: _____

Please answer the questions below:

What county do you live in? _____

Are you associated with a Mental Health Organization? If yes, please specify which one:

_____

Why do you want to learn the **WRAP®** (Wellness Recovery Action Plan) system?

_____

_____

_____

_____

Would you like to be a Peer Support Specialist? YES_____ NO_____ MAYBE_____