

**Treatment Verification Form  
Indiana Certified Recovery Specialist Program**

In order to complete the Certified Recovery Specialist training application, training applicants are required to obtain documentation from a current or past provider of behavioral health services that verifies current or past treatment participation. Below is a form that may be used to complete that requirement.

Date: \_\_\_\_\_

This document verifies that \_\_\_\_\_ received  
behavioral health services through this office.

\_\_\_\_\_  
Signature (written)

\_\_\_\_\_  
Signature (printed)

\_\_\_\_\_  
Provider Organization

\_\_\_\_\_  
Street address, City, State, Zip

\_\_\_\_\_  
Contact phone number

**Please fax, scan and email or mail to:**

Tiffany Wicker  
ASPIN  
3600 Woodview Trace, Ste. 103  
Indianapolis, IN 46268  
FAX: 317-471-1891  
[twicker@aspin.org](mailto:twicker@aspin.org)

**THANK YOU!**