This self-evaluation is designed to increase your awareness in preparation for Recovery Transition Program (RTP) Peer Mentor training course and to give the instructors an introduction to you and some understanding of your knowledge and skills. Please keep in mind, the RTP is not a treatment program and you must have a plan for your own care should you need it.

**Instructions:**

* This form is designed to expand as you type in your answers. If it is easier for you to write them out by hand, then go ahead as answer the questions on a separate sheet of paper and indicate the numbers.
* Please return the filled form to Patricia Lucas (patricia.lucas@muhc.mcgill.ca)

|  |  |
| --- | --- |
| 1. Name
 |  |
| 1. Date
 |  |
| 1. Why do you want to be a peer mentor?
 |  |
| 1. How do you think this program will benefit you?
 |  |
| 1. What does recovery mean to you and how does it apply to being a peer mentor?
 |  |
| 1. How do you believe you can be an effective role model for a consumer of mental health services? **Please describe your own use of recovery-oriented resources in the community?**
 |  |
| 1. Thinking back to any experience you’ve had with counselling or therapy, what are the qualities of a helper that were…
 | a) most beneficial? |
| b) least beneficial? |
| 1. What would you do if someone you were supporting wanted to do something that goes against your personal beliefs?
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| 1. What do you do to help when you are down or stressed? (Coping strategies and self-management tools). Please describe your own self-care practices
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| 1. Have you any training or experience related to peer support? Please explain
 |  |
| 1. Have you utilized peer support as part of your recovery? Been involved in peer led groups?
 |  |
| 1. Are you willing to use your own recovery story and experience in a way that provides hope to others?
 |  |
| 1. Are you able to commit to an intensive online, 30-hour training over a 6-week period?
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| 1. What else would you like the trainer to know about you that would help them understand you?
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| 1. Contact information:

PhoneEmailAddress |  |

**PLEASE NOTE: REFERRAL FROM YOUR PRIMARY HEALTHCARE PROVIDER (HCP) IS REQUIRED**

**Name and contact information of referring HCP:** (please print)

**Signature: Date:**