MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES (DPHHS)
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES DIVISION (BHDD)

APPLICATION FOR CERTIFICATION AS A
MENTAL HEALTH PROFESSIONAL PERSON (MHPP)

PART II – EMPLOYMENT INFORMATION

TO THE APPLICANT: Provide the information requested below to claim credit for work experience required for certification. The committee looks for at least two years of mental health clinical experience, which can include work experience acquired as an in-training candidate for clinical professional licensure. If you have more than one work experience to claim, send a separate form to each employer, so that each experience is documented. After completed Sections A through E below, send the form to the person who supervised your work (or another authorized representative of the employer) for verification. The supervisor or authorized representative must forward the completed form directly to the Certification Committee.

APPLICANT NAME:

A. Employer Name: Phone:

Address: City/State/Zip:

Name of Supervisor:

Dates of Employment: # of years with employer:

B. Job Title: ☐ Full-time ☐ Part-time
If part-time, hours per week:

C. Is this employer an agency, organization, or unit within an organization in which the primary responsibility is the treatment of mental disorders? ☐ Yes ☐ No ☐ Unknown

If no, is this your private practice employment? ☐ Yes ☐ No

D. What percentage of your time in this job was spent in the following duties *(must total 100 percent)*:

- Providing direct mental health services to seriously mentally ill persons?
  ◯ 100% ◯ 90% ◯ 80% ◯ 70% ◯ 60% ◯ 50% ◯ 40% ◯ 30% ◯ 20% ◯ 10% ◯ 0%
- Evaluating persons for possible serious mental illness?
  ◯ 100% ◯ 90% ◯ 80% ◯ 70% ◯ 60% ◯ 50% ◯ 40% ◯ 30% ◯ 20% ◯ 10% ◯ 0%
- Engage in treatment plan meetings?
  ◯ 100% ◯ 90% ◯ 80% ◯ 70% ◯ 60% ◯ 50% ◯ 40% ◯ 30% ◯ 20% ◯ 10% ◯ 0%
- Documenting for the medical record (e.g., assessments, treatment plans, progress notes)?
  ◯ 100% ◯ 90% ◯ 80% ◯ 70% ◯ 60% ◯ 50% ◯ 40% ◯ 30% ◯ 20% ◯ 10% ◯ 0%

Other duties as assigned? Click or tap here to enter text.
◯ 100% ◯ 90% ◯ 80% ◯ 70% ◯ 60% ◯ 50% ◯ 40% ◯ 30% ◯ 20% ◯ 10% ◯ 0%

Name of Applicant:

E. Describe briefly, in narrative form, the nature of the work you performed for this employer (e.g., case management, individual and group therapy, etc.).

F. Is this employment for your private practice employment? ☐ Yes ☐ No

I certify that the above information is true to the best of my knowledge:

Applicant Signature: Date:

G. FOR THE EMPLOYER

The person named above is an applicant for certification as a Mental Health Professional Person by the State of Montana. In accordance with Montana law, the MHPP has many responsibilities including the evaluation and assessment of persons struggling with a severe mental illness and authority to provide expert testimony regarding commitment hearings, among other duties and responsibilities. Your signature below attests that you have read the information provided by the applicant in sections A through E of this form, and that ***you certify that the information is true to the best of your knowledge***.

Print Name and Title: Signature:

Date:

Return this form and all supporting documents to:

MHPP Certification Committee
Behavioral Health and Developmental Disabilities Division (BHDD)
PO Box 202905
Helena, MT 59620-2905
Fax: 406-444-7391 or -9389
Email to YGentile@mt.gov