STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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

A. Personal Information

Name: _____ **Date:** _____

Home Address: _____ _____
Street Name / PO Box — Home Phone/Cell #

_____ _____
City — State — Zip

Work Address: _____ _____
Line 1 — Work Phone #

_____ _____
City ST Zip — Email

_____ _____
MHPP# & Expiration Date — License Type & Number (LCPC, LCSW, RN…)

B. Education and Training

List below any education and training you received *since your last certification review* and information relevant to your application for renewal (this includes continuing education units). The information listed under each heading is required for certification renewal. In the event of an audit, you will be asked to supply either the course agenda or a certificate of completion.

Name of Program	Title of Training	CEUs	Date

Name of Applicant:_____ **Certificate No.:**_____

C. Employment History

Use the space below and/or a separate sheet of paper to list all employment you have had in the last three (3) years and describe your duties. Be sure to include the dates employed in each position.

Name of Applicant: _____ **Certificate No.:** _____

D. Current Employment Information

Employer: _____ Phone: _____

Address: _____

Name of Supervisor: _____

Dates of Employment: _____

☐ Full Time ☐ Part Time Job Title: _____

Department and Position: _____

Is this employer an agency, organization, or unit within an organization in which the primary responsibility is the treatment of mental disorders? ☐ Yes ☐ No ☐ Not Sure

Percentage of your time in this job spent

providing direct mental health treatment to seriously mentally ill persons: % _____

evaluating persons for possible serious mental illness: % _____

conducting long-term treatment planning for seriously mentally ill persons: % _____

management/supervision of a mental health agency: % _____

Other Major Duties:

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

_____ % _____

100%

Describe briefly, in narrative form, the nature of the work you perform for this employer:

Describe briefly, in narrative form, how you have used this certification in the last three years:

Describe briefly, in narrative form, how you plan to continue to utilize this certification:

TO THE APPLICANT:

1. If you are employed, have your supervisor sign below prior to returning this form.
2. If you are in private practice, or are the head of your organization, **sign below to indicate that the information provided is true to the best of your knowledge and to certify that you continue to perform satisfactorily in direct treatment of mentally ill persons or direct supervision of mental health treatment programs**.

TO THE EMPLOYER: The person named above is an applicant for re-certification by the State of Montana as a Mental Health Professional Person. Montana law gives the Mental Health Professional Persons a number of responsibilities, including the authority to provide expert testimony regarding the need for institutionalization at commitment hearings and to develop and supervise treatment plans for individuals in mental health inpatient facilities. **Your signature below indicates that you have read the information provided by the applicant in Section D of this form, and you certify the information is true to the best of your knowledge and that this applicant continues to perform satisfactorily in direct treatment of mentally ill persons or in direct supervision of a mental health treatment program**.

Signature of Supervisor (or Applicant in private practice) _____ Date _____

Printed Name and Title _____

Return this form and all supporting documents to:

Prof. Person Certification Committee
Addictive & Mental Disorders Division PO Box 202905
Helena, MT 59620-2905
Fax: 406-444-9389
Send through secure email method to:bgraziano@mt.gov

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