**Application for Certification as a Certified Preadmission Screening Clinician**

Under Criteria effective July 1, 2016

Name of Applicant: **Click here to enter text.**

Name of Community Services Board: **Click here to enter text.**

For each item, documentation must be retained and available for review.

**Educational Requirements:**

Please indicate the option by which the individual meets educational requirements

Currently holds a license as:

(Documentation must be retained and available for review.)

|  |  |
| --- | --- |
|  | Select all that apply |
| Licensed Professional Counselor |  |
| Licensed Clinical Social Worker |  |
| Licensed Marriage and Family Therapist |  |
| Licensed Clinical Psychologist |  |
| Psychiatric Nurse Practitioner |  |
| Psychiatric Clinical Nurse Specialist MD/DO |  |

Currently approved for and enrolled in supervision for a license for one of the licenses listed above.

(Documentation must be retained and available for review.)

Holds a Master’s or Doctoral degree that would be required for the following:

(Documentation must be retained and available for review.)

|  |  |
| --- | --- |
|  | Select all that apply |
| Licensed Professional Counselor |  |
| Licensed Clinical Social Worker |  |
| Licensed Marriage and Family Therapist |  |
| Licensed Clinical Psychologist |  |
| Psychiatric Nurse, Psychiatrist |  |
| Clinical Nurse Specialist, Psychiatrist MD/DO |  |

Bachelors prepared nurse [BSN] with five years behavioral health related experience

(Documentation must be retained and available for review.)

**If this is a request under provisions for retaining experienced staff who do not meet the enhanced qualifications, complete the following:**

*[NOTE: If an individual meets the requirements that become effective July 1, 2016 do NOT request certification under these criteria even if they apply, request certification under the July 1, 2016 criteria.]*

Hired prior to July 1, 2008 and has continually been employed in a prescreener role.

Indicate date of hire: **Click here to enter a date.**

Hired between July 1, 2008 and June 30, 2016 and the individual met the education requirements in effect at the time they were originally certified.

Indicate date of hire: **Click here to enter a date.**

For reference, the following is a link to criteria placed into effect July 1, 2008:

<http://www.dbhds.virginia.gov/library/mental%20health%20services/omh-guidance-memo-indep-examin-062608.pdf>

**DBHDS Training:**

Individual has successfully completed all training required for certification by DBHDS.

(Documentation must be retained and available for review.)

**Orientation:**

All orientation requirements have been met and individual is competent to be certified.

(Completed orientation checklist must be retained and available for review.)

Signature of Individual to be certified:

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

The following signatures attest that this individual has met all requirements and is competent to be certified:

Signature of Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of ES Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approval of submission for certification:

Signature of Executive Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_