STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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. If you have had more than one work experience to claim, make additional copies of this form so that each experience is documented. After completing 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 must forward the form directly to the Certification Committee.

Applicant Name: _____

A. Employer: _____ Phone: _____

Address: _____

Name of Supervisor: _____

Dates of Employment: _____

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 ☐ ☐ Not Sure

D. What percentage of your time in this job was spent:

- providing direct mental health services to seriously mentally ill persons? _____%
- evaluating persons for possible serious mental illness? _____%
- doing long-term treatment planning for seriously mentally ill persons? _____%

Other major duties:

_____ _____%

_____ _____%

_____ _____%

_____ _____%

TOTAL 100 %

MHPP – PART II

Applicant Name: _____

E. Describe briefly, in narrative form, the nature of the work you performed for this employer: (Please indicate whether you performed case management, clinical therapy or both.)

TO THE EMPLOYER

The person named above is an applicant for certification by the State of Montana as a MHPP. In accordance with Montana law, the MHPP has many 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 Sections A through E of this form, and ***you certify that the information is true to the best of your knowledge.***

Signature of Employer: _____

Printed Name and Title: _____

Date: _____

Return this form to: Prof. Person Certification Committee
Addictive & Mental Disorders Division
P.O. Box 202905
Helena, MT 59620-2905
Fax: (406) 444-9389
Send through a secure email method to:
bgraziano@mt.gov