INSTITUTE FOR CHILD AND FAMILY HEALTH, INC.
MATERNAL MENTAL HEALTH TRAINING
APPLICATION FORM

Please PRINT clearly. Use additional pages when needed.

SECTION I: PERSONAL INFORMATION

Name _____

Home Address _____

Phone (_____) _____ FAX (_____) _____

E-Mail _____ Cellular Phone _____

Please list your professional discipline and Florida professional license number:

_____

List any other state(s) in which you are licensed _____

Do you work under supervision? ___No __Yes If yes, who is your supervisor? _____

LANGUAGES
Please list all languages and extent of fluency:

_____

SECTION II: EDUCATIONAL BACKGROUND

COLLEGES / UNIVERSITIES ATTENDED

College/University	City/State/County	Dates Attended	Degree	Major
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SECTION III: TRAINING IN INFANT MENTAL HEALTH

Have you attended a training on infant mental health, such as the 9-month program offered at ICFH?
Please describe:

Title of Training	Instructor	Dates	Location
Title of Training	Instructor	Dates	Location

<u>SECTION IV</u>: EXPERIENCES/WORK WITH CHILDREN UNDER 5

1. Setting _____

Age range of clients:_____ Dates _____ Position _____

Address _____

Description of your experience:

2. Setting _____

Age range of clients:_____ Dates _____ Position _____

Address _____

Description of your experience:

3. Setting _____

Age range of clients:_____ Dates _____ Position _____

Address _____

Description of your experience:

SECTION V: EXPERIENCES/WORK WITH PARENTS & ADULTS

1. Setting _____

Dates _____ Position _____

Address _____

Description of your experience:

2. Setting _____

Dates _____ Position _____

Address _____

Description of your experience:

3. Setting:_____

Dates _____ Position _____

Address _____

Description of your experience:

SECTION VI: AGENCY INFORMATION

Current Employer/Name of Agency _____

Address _____

Position _____ Dates Employed _____

Age of population served by your agency _____

Where does your agency see clients? ____School ____Home ____Clinic _____Other:_____

Is there a playroom available to work with clients? _____ Yes _____ No

How many clients do you typically have on your open case load? _____

Cultural/ethnic diversity of the population your agency serves:_____

Percent of service population that is Medicaid eligible _____

Do you bill Medicaid for your services _____ No _____ Yes

Do you use DSM V or ICD-10 Codes? _____ No _____ Yes

Range of behaviors treated in the social-emotional domain:

What, if any, assessment tools are you most familiar with (Specify child, family, adult)?

What treatment modalities or theoretical frameworks do you use most with children?

SECTION IX: Memorandum of Agreement

I agree to participate in the 3-month Maternal Mental Health Training Program sponsored by The Institute for Child and Family Health, Inc. and conducted by a team of experts in the field. I understand that the following conditions for my participation in this training program apply and I agree to these conditions:

1. I will be expected to attend all training sessions**.** In the event of a missed session due to an emergency, the Director of Early Childhood Services will make the decision as to whether makeup work is possible, and how it is to be completed.

2. During the 3 months of the program, I will complete a total of **16.5 hours** on Maternal Mental Health, from **July 20th, 2017 through September 28th, 2017.** This includes attendance in 100% of the 3 Workshops (3 sessions) consisting of 5.5 hours per session (16.5 hours).

3. I will read the required materials and participate actively in class discussions.

4. I will participate in ongoing evaluations to determine the impact of the training, and to complete follow-up surveys after the program is over to report clinical and professional activities related to the training.

_____

Print Applicant's Name

_____ **Date** _____

Applicant's Signature

Please complete the next page.

Due to the time commitment required for this program, the following must be completed as part of this application:

I am the Executive Director of the agency where the above-named applicant works. I agree to allow the applicant to participate in the Infant Mental Health Training Program at the Institute for Child and Family Health, Inc. I understand the conditions for the applicant's participation and the commitment it will require, including that this employee attends all the sessions indicated on this agreement, as well as participate in the activities listed above.

_____

Name of Agency

_____

Executive Director's Name

_____ **Date** _____

Executive Director's Signature

This application, must be received by Wednesday, July 14th, 2017
Please mail or E-mail these to:

Maite Schenker, Ph.D.
Institute for Child and Family Health, Inc.
Director of Early Childhood Services
15490 NW 7th Avenue
Miami, FL 33169

mschenker@icfhinc.org