

# *Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (IMH-E®)*

## Annual Professional Development Update

Please complete and return via email or postal mail: (see contact information below)

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |

Endorsement Level: Level I  Level II  Level III  Level IV

Year:

**REQUIRED: 15 HOURS TRAINING ANNUALLY**

Please provide a list of ***specialized*** in-service trainings/conferences attended specific to culturally sensitive, relationship-focused practice promoting infant mental health.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Title of Training: | |  | | | | |
| Name of Trainer: | | | |  | | |
| Location of Training: | | | |  | | |
| Sponsor of Training: | | | |  | | |
| Date (s) |  | | | |  | |
| Number of Hours: | | |  | | |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Title of Training: | |  | | | | |
| Name of Trainer: | | | |  | | |
| Location of Training: | | | |  | | |
| Sponsor of Training: | | | |  | | |
| Date (s) |  | | | |  | |
| Number of Hours: | | |  | | |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Title of Training: | |  | | | | |
| Name of Trainer: | | | |  | | |
| Location of Training: | | | |  | | |
| Sponsor of Training: | | | |  | | |
| Date (s) |  | | | |  | |
| Number of Hours: | | |  | | |  |

Add additional trainings, as needed (complete separate form)

**RECOMMENDED: REFLECTIVE CONSULTATION**

If appropriate, please provide a list of reflective consultation experiences specific to culturally sensitive, relationship-focused practice promoting infant mental health. This is not required but recommended for best practice at Levels II, III & IV.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Consultant: | | |  | | | |
| Agency/Office where consultation occurred: | | | | | |  |
| Frequency: | |  | | | |  |
| Dates: |  | | | | |  |
| Total number of hours: | | | |  |  | |
| Group  Individual | | | | | | |

*Add additional reflective consultation experiences, as needed*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Consultant: | | |  | | | |
| Agency/Office where consultation occurred: | | | | | |  |
| Frequency: | |  | | | |  |
| Dates: |  | | | | |  |
| Total number of hours: | | | |  |  | |
| Group  Individual | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Consultant: | | |  | | | |
| Agency/Office where consultation occurred: | | | | | |  |
| Frequency: | |  | | | |  |
| Dates: |  | | | | |  |
| Total number of hours: | | | |  |  | |
| Group  Individual | | | | | | |

*Thank you for renewing your OK-AIMH Endorsement*