

# *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: |       |  |

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

|  |  |
| --- | --- |
| 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*