

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

## Preliminary Application

Please complete and return via postal mail

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | |  | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | |
|  | | City State Zip | | | | | | | | | | | | |
| Daytime Telephone: | | | | | | | |  | | | | Evening Telephone: | |  |
| Email: | | |  | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | |
| **Education:** (Select All That Apply) | | | | | | | | | | | | | | |
| HS Diploma  GED  CDA  AD  BA  BS  BSW MSW | | | | | | | | | | | | | | |
| MA  MS  MSN  Med  IMH Certificate  PhD  MD PsyD | | | | | | | | | | | | | | |
| JD  Other | | | | | |  | | | | |  | | | |
| **Year that highest degree was earned:** | | | | | | | | | |  | | |  | |
|  | | | | | | | | | |  | | |  | |
| **Work Experience(s) with/related to infants, toddlers and their families:\***  Total number of year paid work experience with or on behalf of infants/toddlers and/or their families: | | | | | | | | | | | | | | |
| **Current Employer:** | | | | | | |  | | | | | | | |
| **Work Address** | | | |  | | | | | | | | | | |
| **Title:** |  | | | | | | | | | | | | | |
| **Responsibilities:** | | | | |  | | | | | | | | | |
| **Dates of employment:** | | | | | | | | |  | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **If relevant, previous employer:** | | | | | | | |  | | | |
| **Work address:** | | | |  | | | | | | | |
| **Title:** |  | | | | | | | | | | |
| **Responsibilities:** | | | | |  | | | | | | |
| **Dates of employment:** | | | | | |  | | | | | |
|  | | | | | |  | | | | | |
| **Reflective Consultation:** | | | | | | | | | | | |
| Provider: | |  | | | | | | | | | |
| Location/context of consultation: | | | | | | | | |  | | |
| Dates received: | | |  | | | | | | | | |
| Total hours (group and/or individual): | | | | | | | | | |  |  |
|  | | | | | | | | | | | |
| OK-AIMH Membership current? | | | | | | | Yes  No | | | | |
| You must join or renew membership to OK-AIMH (or another infant mental health association) when submitting this preliminary application. Request a membership form at [okaimh@gmail.com](mailto:okaimh@gmail.com) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Please select the level at which you are applying. | | | | | | | | | | | |
| Infant Family Associate (Level I) $15.00  Infant Family Specialist (Level II) $15.00 | | | | | | | | | | | |
| Infant Mental Health Specialist (Level III) $ 25.00 | | | | | | | | | | | |
| Infant Mental Health Mentor (Level IV) $ 25.00 | | | | | | | | | | | |
| Clinical  Policy  Research/Faculty | | | | | | | | | | | |

Please send preliminary application, résumé and fee (check made payable to OK-AIMH), Attention Bonnie Bellah, P.O. Box 685, Oklahoma City, OK 73101. Once the application has been reviewed, you will receive additional details about the OK-AIMH Endorsement, instructions for completing the process, and connected with a volunteer Endorsement Advisor.

**NOTE: All Return Checks will be assessed a $25.00 Return Check Fee**

*Thank you for your interest in OK-AIMH Endorsement*