

APPLICATION FOR CERTIFICATION AS A CERTIFIED PREADMISSION SCREENING CLINICIAN
Under Criteria effective July 1, 2016

Name of Applicant:

Name of Community Services Board:

For each item, documentation must be retained and available for review.

Educational Requirements:

Please indicate the option by which the individual meets educational requirements

Currently holds a license as:
(Documentation must be retained and available for review.)

Select all
that apply

- | | |
|---|--------------------------|
| Licensed Professional Counselor | <input type="checkbox"/> |
| Licensed Clinical Social Worker | <input type="checkbox"/> |
| Licensed Marriage and Family Therapist | <input type="checkbox"/> |
| Licensed Clinical Psychologist | <input type="checkbox"/> |
| Psychiatric Nurse Practitioner | <input type="checkbox"/> |
| Psychiatric Clinical Nurse Specialist MD/DO | <input type="checkbox"/> |

Currently approved for and enrolled in supervision for a license for one of the licenses listed above.
(Documentation must be retained and available for review.)

Holds a Master's or Doctoral degree that would be required for the following:
(Documentation must be retained and available for review.)

Select all
that apply

- | | |
|---|--------------------------|
| Licensed Professional Counselor | <input type="checkbox"/> |
| Licensed Clinical Social Worker | <input type="checkbox"/> |
| Licensed Marriage and Family Therapist | <input type="checkbox"/> |
| Licensed Clinical Psychologist | <input type="checkbox"/> |
| Psychiatric Nurse, Psychiatrist | <input type="checkbox"/> |
| Clinical Nurse Specialist, Psychiatrist MD/DO | <input type="checkbox"/> |

Bachelors prepared nurse [BSN] with five years behavioral health related experience
(Documentation must be retained and available for review.)

If this is a request under provisions for retaining experienced staff who do not meet the enhanced qualifications, complete the following:

[NOTE: If an individual meets the requirements that become effective July 1, 2016 do NOT request certification under these criteria even if they apply, request certification under the July 1, 2016 criteria.]

- Hired prior to July 1, 2008 and has continually been employed in a prescreener role.
Indicate date of hire:
- Hired between July 1, 2008 and June 30, 2016 and the individual met the education requirements in effect at the time they were originally certified.
Indicate date of hire:

For reference, the following is a link to criteria placed into effect July 1, 2008:

<http://www.dbhds.virginia.gov/library/mental%20health%20services/omh-guidance-memo-indep-examin-062608.pdf>

DBHDS Training:

- Individual has successfully completed all training required for certification by DBHDS.
(Documentation must be retained and available for review.)

Orientation:

- All orientation requirements have been met and individual is competent to be certified.
(Completed orientation checklist must be retained and available for review.)

Signature of Individual to be certified:

_____ Date: _____

The following signatures attest that this individual has met all requirements and is competent to be certified:

Signature of Supervisor: _____ Date: _____

Signature of ES Manager: _____ Date: _____

Approval of submission for certification:

Signature of Executive Director: _____ Date: _____