APPLICATION FOR RECERTIFICATION: MENTAL HEALTH TECHNICIAN

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION
SFN 594 (3-2016)

Clear Fields

Type or print using black or blue ink pen (no pencil). Incomplete or indecipherable forms will not be accepted and may result in a delay in certification.

APPLICANT INFORMATION

Name of Applicant (Last, First, MI)		
Name of Agency	Agency Telephone Number	
Agency Mailing Address		
City	State	ZIP Code
Name of Immediate Supervisor	Immediate Supervisor Telephone Number	
Email Address		

PREREQUISITES (ANNUAL UPDATE)

Prerequisite	Date	Exception (explain)
CPR Certification	Expiration Date	
First Aid Training	Expiration Date	
Crisis Intervention/Prevention Training	Expiration Date	
HIPAA & Confidentiality Training (Completed annually)	Date Completed	
42 CFR Part 2 Review (Completed annually)	Date Completed	

RECERTIFICATION TRAINING CONTACT HOURS

Total Number of Recertification Training Contact Hours Claimed

Applicants must complete the Recertification Training section (next page) for each training submitted for credit. Attach additional sheets, if needed. Four (4) contact hours are required each year for recertification.

SIGNATURES

I acknowledge the authenticity of the information provided on this application.

Applicant Signature (your typed name will represent your signature)	Date
Supervisor Signature (your typed name will represent your signature)	Date

STATE OFFICE USE ONLY

Recertified? ☐ Yes ☐ No	Date Issued

RECERTIFICATION TRAINING

Training Title	
Date Training Completed	Number of Contact Hours

Core Competence Areas (check all that apply)

- ☐ Psychiatric Disorders
- ☐ Universal Precaution/Safety
- ☐ Documentation
- ☐ Consumer and Children's Rights
- ☐ Ethics/Cultural Competency

Synopsis of Training

Training Title	
Date Training Completed	Number of Contact Hours

Core Competence Areas (check all that apply)

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- ☐ Documentation
- ☐ Consumer and Children's Rights
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Synopsis of Training

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Synopsis of Training

APPLICATION INSTRUCTIONS

Applicant Information:

Name of Applicant: Enter Applicant's Full Name
Name of Agency: Enter the Agency's Legal Name
Agency Telephone: Enter the Agency's telephone number
Agency Address: Enter the street address of the agency
City, State, Zip Code: Enter the Agency's City, State, and Zip Code that corresponds with the street address
Name of Immediate Supervisor: Enter the first and last name of the applicant's immediate supervisor
Immediate Supervisor Telephone: Enter the telephone number of the Applicant's immediate supervisor
Email Address: Enter email address where certificates will be sent to

Prerequisites:

CPR Certification: Identify the expiration date of the Applicant's CRP certification. If there are exceptions please note the exception. Exceptions must be approved by the Behavioral Health Division before certification will be made. Attach additional documentation, if needed.

First Aide Training: Identify the expiration date of the Applicant's First Aide certification. If there are exceptions please note the exception. Exceptions must be approved by the Behavioral Health Division before certification will be made. Attach additional documentation, if needed.

Crisis Intervention/Prevention Training: Identify the expiration date of the Applicant's Crisis Intervention/Prevention Training certification. If there are exceptions please note the exception. Exceptions must be approved by the Behavioral Health Division before certification will be made. Attach additional documentation, if needed.

HIPAA & Confidentiality Training: To be completed annually. Identify the date the Applicant was last trained. If there are exceptions please note the exception. Exceptions must be approved by the Behavioral Health Division before certification will be made. Attach additional documentation, if needed.

42 CFR Part 2 Review: To be completed annually. Identify the date the Applicant was last trained. If there are exceptions please note the exception. Exceptions must be approved by the Behavioral Health Division before certification will be made. Attache additional documentation, if needed.

Recertification Training Contact Hours:

Total number of Recertification Training contact hours being claimed: Enter the total contact hours being claimed. Documentation must match the number of hours claimed or the application will be rejected. Cannot be one of the 5 prerequisites listed above.

Signatures:

Applicant: Applicant sign and date to acknowledge the authenticity of the information provided.

Immediate Supervisor: Immediate supervisor sign and date to acknowledge the authenticity of the information provided.

State Office Only:

This section reserved for Behavioral Health Division review.

Recertification Training:

Training Title: The title of the training the Applicant attended.

Date Training Completed: Identify the date the Applicant completed the training.

Number of Contact Hours: The total number of contact hours approved for the training.

Core Competence Areas: Check all of the core competence areas that the training applies to.

Synopsis of Training: Briefly summarize the content of the training. Attach additional documentation, if needed.