

Hamilton County  
Mental Health Recovery Services Board

**HEALTH OFFICER DESIGNATION - APPLICATION**

PRINT NAME \_\_\_\_\_ DATE \_\_\_\_\_

AGENCY/FACILITY \_\_\_\_\_

AGENCY ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

YEARS WITH THE AGENCY \_\_\_\_\_ YEARS WORKING WITH SMI \_\_\_\_\_

PROFESSIONAL CREDENTIALS \_\_\_\_\_ LICENSE NUMBER \_\_\_\_\_

STATE YOUR NEED FOR HEALTH OFFICER DESIGNATION IN YOUR CURRENT ROLE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are being asked to have senior leadership from your organization sign off on your request to become a Health Officer. It is important to know that when signing a Statement of Belief, you are acting as an agent of your organization, not independently, and performing your duties as a Health Officer may subject you and the organization to liabilities.

PRINT NAME OF AGENCY REPRESENTATIVE \_\_\_\_\_

AGENCY REPRESENTATIVE'S SIGNATURE \_\_\_\_\_

TITLE \_\_\_\_\_

**If Renewing, did you complete 3 CEU's in mental health in the past 2 years?**    Y    N

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_