



HEALTH OFFICER DESIGNATION - APPLICATION

PRINT NAME _____ DATE _____

AGENCY/FACILITY _____

AGENCY ADDRESS _____

CITY _____ STATE _____ ZIP _____

AGENCY PHONE _____ APPLICANT PHONE _____

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 a 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 _____

Return signed application to Kayl@hcmhrsb.org