Mental Health Integrative Medicine Institute

Application for Certified Mental Health Integrative Medicine Provider (CMHIMP)

Date: _____

Name (as it appears on your license):_____

Mailing Address:_____

City/State/Zip/Country:_____

Phone: _____

Email Address:_____

I attest to the following (please initial each):

____I am a State or Nationally licensed (or equivalent outside the U.S.) professional as outlined in Criterion 1.1 of the Certification Standards

____My professional license, membership, registration, certification or designation is current and in good standing as outlined in Criterion 1.2 of the Certification Standards

____I have completed the required 18 education clock hours of training as outlined in outlined in Criterion 2.1 of the Certification Standards

____ I have conducted a minimum of 20 clinical sessions with clients in which nutritional and integrative medicine approaches were discussed as part of a comprehensive mental health treatment plan as outlined in Criterion 3.0 of the Certification Standards

I verify that this application is complete, accurate, and that the information provided and attested to is factual and true. I understand that if any of the information provided and attested to is false or found to be false, my certification will be denied and/or revoked, and my licensing board may be contacted.

I understand that information submitted with this application may be verified for accuracy by the Mental Health Integrative Medicine Institute. I also agree to contact the Mental Health Integrative Medicine Institute in the event that I no longer meet the requirements to be a Certified Mental Health Integrative Medicine Provider.

Signed: _____ Date: _____