

APPLICATION FOR INFANT AND CHILD MENTAL HEALTH POST-BACCALAUREATE CERTIFICATE PROGRAM

Sponsored by the Brown Center for the Study of Children at Risk, The Alpert Medical School of Brown University, Women and Infant's Hospital, and Brown University Office of Continuing Education



Brown University, Box T
Providence, Rhode Island 02912-9120
Tel 401-863-7900 Fax 401-863-3916
Email: summer@brown.edu
www.brown.edu/summer

PERSONAL INFORMATION Please print

Name _____

Other names that may appear on credentials _____

Date of Birth _____ Social Security Number _____

Preferred mailing address _____

City/State/Zip _____

Residence Address (if different from above) _____

Home Phone _____ Work phone _____ Cell _____

Fax _____ Email _____

Profession _____ Specialty _____ # of years experience _____

Please check the program for which you are applying:

- Clinical Track Clinical and Research Track

EDUCATIONAL INFORMATION Use chronological order starting with the most recent. Please send a copy of transcript from highest degree; an unofficial student transcript is acceptable.

Name of College or University	City & State	Major	Graduation Date	Degree Received

PROFESSIONAL LICENSE AND/OR CREDENTIAL DATA Please complete the following information and attach a photocopy of each license and credential.

Type of License or Credential	Issuing State Board or Professional Organization	License or Credential #	Effective Date	Expiration Date

NOTE If you do not have a professional license or credential, please submit a letter from your current institution verifying you are in the process of obtaining a license in a field or discipline providing services for infants/children.

MALPRACTICE INSURANCE Please complete the following information and send a photocopy of your certificate of malpractice insurance. Each student in the Infant and Child Mental Health Post-baccalaureate Certificate Program will maintain professional malpractice insurance with limits of at least \$1,000,000 per occurrence and at least \$3,000,000 in the annual aggregate.

- Name of Insurance Company _____
- Address of Insurance Company _____
- Policy Number _____
- Coverage Provided _____

STATEMENT OF INTEREST Please attach a brief description of your interest in the infant and child mental health field and the relevance of this course of study to your work with children and families (no more than 100 words).

RESEARCH (for Research Track applicants) Briefly describe your research interests in the infant and child mental health field and the relevance of this course of study to your work with children and their families. Please attach a summary of relevant research experience including publications and presentations.

EMPLOYMENT DATA List employment that totals at least 2 years of work experience with children. It is not necessary to list employment beyond that needed to show the 2 years of work experience.

Employer (list 'self' if applicable)	
Employment address	
Employment title or job (role)	
Date you started this employment	
Date employment ended (if applicable)	
Hours per week typically worked	
Typical percent of time dedicated to serving children and their families	
Briefly describe your work in this setting:	

NOTE It is not necessary to list employment beyond that needed to show the 2 years of work experience with children.

Employer (list 'self' if applicable)	
Employment address	
Employment title or job (role)	
Date you started this employment	
Date employment ended (if applicable)	
Hours per week typically worked	
Typical percent of time dedicated to serving children and their families	
Briefly describe your work in this setting:	

Use additional sheets, if needed.

PROFESSIONAL ACTIVITIES

A. Indicate the discipline(s) in which you are licensed, certified and/or credentialed. Check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Social Worker/LCSW | <input type="checkbox"/> Dietician |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Marriage & Family Therapist | <input type="checkbox"/> Other, please list: _____ |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Educator | |

B. Indicate the type of practice setting(s) you work in. Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Private/not-for-profit agency | <input type="checkbox"/> Community Clinic | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Public School System | <input type="checkbox"/> Kaiser | <input type="checkbox"/> Self-employed |
| <input type="checkbox"/> Private School | <input type="checkbox"/> Public or Governmental Agency | <input type="checkbox"/> Other, please list: _____ |
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Hospital | |

C. Estimate the PERCENT of your time in a typical workweek spent in the following activities:

_____	_____	_____	_____	_____	_____	_____	=	_____	100%
direct services	supervising staff	administering programs	training	influencing public policy	research	other/list		total	

D. When performing the activities in "C" (above), estimate the PERCENT of your time in a typical workweek spent serving or performing activities for children of the following ages or their parents:

_____	_____	_____	_____	_____	_____	_____	=	_____	100%
prenatal	birth to 12 months	12 to 24 months	24 to 36 months	36 to 48 months	48 to 60 months	other		total	

E. When performing the activities in "C" (above), estimate the PERCENT of your time in a typical workweek spent serving or performing activities in the following areas for children 0-5 or their parents:

_____	_____	_____	_____	_____	_____	=	_____	100%
preventative services	screening	early intervention	formal assessments	assessment-driven therapy	other/list		total	

APPLICATION CHECKLIST Please initial each statement.

1. _____ I have reviewed the course training dates. I understand and agree that missing more than 20% of mandatory training will result in me not being eligible for my certificate of completion.
2. _____ I understand and agree that my certificate of completion from Brown University will be provided only after I have completed all course requirements explained in the program description.
3. _____ I understand and agree that my tuition is due in full within 30 days of receipt of my invoice from Brown. I have reviewed the refund policy on the website.
4. _____ I have reviewed and agree that I will abide by, be subject to, and follow the Women and Infants' Hospital Policy Manual in program clinical activities.
5. _____ I understand and agree that while I am attending the Infant and Child Mental Health Post-baccalaureate Certificate Program (ICMHPCP) at Brown University and Women and Infants Hospital, completing course assignments, completing practicum/ integration hours, participating in workshops, mentorship and reflective practice sessions, meetings with colleagues, and in all other activities related to the ICMHPCP, I will personally be responsible for any liabilities that may arise by reason of my activities while participating in the program, and I further represent and warrant that I have and will be covered by the following malpractice and/or professional liability insurance that insures against damages arising from my activities in the program (please fill in):
 - a. Name of Insurance Company _____
 - b. Address of Insurance Company _____
 - c. Policy Number _____
 - d. Name of Insured _____
 - e. Coverage Provided _____

NOTE Each student in the Infant and Child Mental Health Post-baccalaureate Certificate Program will maintain professional and/or malpractice insurance with limits of at least \$1,000,000 per occurrence and at least \$3,000,000 in the annual aggregate.

I hereby state that the above information is true and correct and I request admission to the Infant and Child Mental Health Post-baccalaureate Certificate Program. I agree to the conditions and responsibilities as described.

Signature _____

Printed Name _____ Date _____

MAILING INSTRUCTIONS A complete application consists of:

1. A completed and signed application
2. Statement of interest (no more than 100 words)
3. For participants applying for the Clinical and Research track, an additional statement describing your research interests and experience
4. A transcript from the University where you obtained your highest degree (a student transcript is acceptable)
5. A photocopy of your professional licenses and credentials or a letter from your current institution verifying you are in the process of obtaining a license in a field or discipline providing services for infants/children.
6. A photocopy of your certificate of insurance. The certificate of insurance must have the name of the company, policy number, address of insurer, and coverage provided.
7. Application fee of \$60 in check or money order payable to Brown University with the program title on the notation line.

Applications will not be processed without these documents. Please make a complete copy of your application before submission.

MAIL COMPLETED APPLICATION PACKET BY JULY 31, 2009 TO:
Office of Continuing Education
Infant and Child Mental Health Post-baccalaureate Certificate Program
Brown University
Box T
Providence, RI 02912