Application for Permission to Provide Coverage At Colorado Mental Health Institute at Fort Logan

For CMHIFL Use Only:

Approved ____Yes ____No
Date Received____________
Reviewed by ____________
Approved ____Yes ____No
Date Agency Notified_________,
by ___________(initials)
All paperwork/tests received:
_____ Yes _____ No

Name of Pool(s) Employed With____

Pool Supervisor's Name______________________________**Phone Number** ____________

Employee Information

Print Name: Last / First / Middle Initial	Maiden/previous name
Address: (Street Name and Number	Date of Birth (month/day/year
City / State / Zip Code	Social Security Number
Phone Number ______________ Home) ______________ Cell)	United States Citizen? ____Yes ____No if not attach copy of employment authorization

Education and Training

Name and Location (City/State) Of Last High School attended	Dates Attended From:	To:	Graduate:	GED Certification Number:
____________	______	______	____Yes ____No	____________ ____n/a

Name and Location of College/ University	Dates Attended: From:	To:	Major:	Type of Degree	Year Degree Awarded
____________	______	______	________	__________	________
____________	______	______	________	__________	________
____________	______	______	________	__________	________
____________	______	______	________	__________	________

Licenses/Certifications

Original Colorado CNA License/Expiration (Copy MUST be attached) ______________ Lic. # ______________ Expiration Date

CPR Certification (attach copy) _____ Yes _____ No ______________ Expiration Date

Crisis Management (from Crisis Prevention Institute only – attach copy) _____ Yes _____ ______________ Expiration date

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WORK EXPERIENCE: (For Mental Health Workers only) Document all psychiatric experience/jobs – add additional sheets if necessary. Start with most recent experience.

______________________ Current Employer	______________ Telephone Number	From: ____/____/____ Mo Day Yr
______________________________ Complete Address		To: ____/____/____ Mo Day Yr
Your Title______________________ Supervisor Name and Title______________________		Hours per Week______

Description of you job:

Type of psychiatric treatment unit:
(Check all that apply) _____Inpatient _____Outpatient _____Residential
_____Other (please specify) ______________________________

______________________ Current Employer	______________ Telephone Number	From: ____/____/____ Mo Day Yr
______________________________ Complete Address		To: ____/____/____ Mo Day Yr
Your Title______________________ Supervisor Name and Title______________________		Hours per Week______

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Complete Address ____

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Your Title ____________________

Supervisor Name and Title ____________________

Hours per Week ____

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Complete Address ____

To: ____/____/____ Mo Day Yr

Your Title ____________________

Supervisor Name and Title ____________________

Hours per Week ____

Description of you job:

Type of psychiatric treatment unit:
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_____Other (please specify) ______________________________

CERTIFICATION: I certify that I possess the experience, education and/or licenses required for the job for which I am applying. I also certify that all statements, information and documents provided with this application are true, complete and correct to the best of my knowledge and are made in good faith.

______________________________ Signature

______________________________ Date