Mental Health Professional/Mental Health Specialist
Instructions

This form should be used to request acknowledgement of Mental Health Professional/ Mental Health Specialist qualifications, while working at a licensed behavioral health agency, as required by WAC 246-341-0200.

Requirements

☐ Complete Mental Health Professional (MHP)/Mental Health Specialist (MHS) acknowledgement request form
☐ Attach all supporting documents as indicated
☐ Email completed request with all supporting documentation to the Department of Health (DOH) at HSQACredentialing@doh.wa.gov

Instructions Checklist

☐ Indicate whether you are requesting acknowledgment of meeting the requirements for MHP, MHS, or both.
☐ Indicate if you are requesting acknowledgement via DOH designation or agency attestation. If requesting via agency attestation, only fill out sections 1-3 of this application.

☐ 1. Demographic Information
   Legal Name: List your full name: first, middle, and last.
   Credential Number: List your DOH credential number. (if applicable)
   Birth date: Provide the month, day, and year of your birth.
   Email: Enter your email address, if you have one.

☐ 2. Agency Information
   Agency Name: List the agency name.
   Agency Credential Number: Provide the credential number of the agency.
   Agency Email: Enter an email address for the agency.
   Agency Address: List the agency’s physical address.

☐ 3. Agency Attestation: Fill out this section ONLY if the agency is attesting that the agency has verified the applicant meets all of the requirements for the MHP/ MHS being requested. If this section is completed, no additional sections of this application are required to be completed. Please note, DOH may verify that the agency attested correctly during routine on-site surveys.
4. **MHP Qualifications** (as required by WAC 246-809-221) Fill out this section only if the agency is not attesting in section 3, and you are requesting MHP acknowledgment

   **Required Documentation attached for review for MHP:**
   - College Transcripts (if applying by Agency Affiliated Counselor path)

5. **MHS Qualifications**: Fill out this section only if the agency is not attesting in section 3, and you are requesting MHS acknowledgment

   **Required Documentation attached for review for MHS**: Specialist Training Documentation and Hours
   - Documentation of supervised hours by a MHS
   - Attestation in place of 100 hours of training (for Ethnic Minority or Disability Mental Health Specialist only)

6. **Supervised Experience by MHP**: Provide MHP name and hours

7. **Supervised Experience by MHS**: Provide MHS name, hours, and specialty area

8. **Applicant’s Attestation**: Sign and date this section if applying by DOH designation.

**In order to process your request:**

Please mail or email your documentation to:

Mental Health Professional Credentialing Section
P.O. Box 47877
Olympia, WA  98504-7877

[HSQACredentialing@doh.wa.gov](mailto:HSQACredentialing@doh.wa.gov)
**Mental Health Professional/Mental Health Specialist**

I am requesting acknowledgment that I meet the requirements for:

- [ ] Mental Health Professional (MHP)  and/or  [ ] Child Mental Health Specialist

- [ ] I am requesting DOH designation  -or-  [ ] I am requesting acknowledgment via Agency Attestation

### 1. Demographic Information

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<tr>
<th>Name: First</th>
<th>Middle</th>
<th>Last</th>
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<tr>
<th>DOH Credential Number (if applicable)</th>
<th>Birth date (mm/dd/yyyy)</th>
<th>Email Address</th>
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### 2. Agency Information

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<th>Agency Name</th>
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<th>Agency Email Address</th>
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### 3. Agency Attestation

I certify that I am an agency representative and have verified that the individual named above meets all experience and credentialing requirements for the designation(s) indicated on this application.

Signature of Agency Representative: ________________  Today’s Date: ________________

Print Name: ____________________________________

Signature of Applicant: _________________________  Today’s Date: _________________________

Print Name: ____________________________________
I am:

- A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 RCW and 71.34 RCW;
- A person who is licensed by the Department of Health as a Mental Health Counselor, Mental Health Counselor Associate, Marriage and Family Therapist or Marriage and Family Therapist Associate;
- A person who is registered by the Department of Health as an Agency Affiliated Counselor who has a master’s degree or further advanced degree, and meets the core study education criteria outlined in WAC 246-809-221. Such person(s) shall have, in addition, at least two years of experience in direct treatment of person(s) with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional.

- This core of study must include seven content areas from the entire list in subsections (1) through (17) of this section, five of which must be from content areas in subsections (1) through (8) of this section. The core of study must also include either a counseling practicum or counseling internship, WAC 246-809-221.

  - **Core of Study (Check all that apply and attach college transcripts for verification)**
    - 1. Assessment/Diagnosis
    - 2. Ethics/Law
    - 3. Counseling Individuals
    - 4. Counseling Groups
    - 5. Counseling Couples
    - 6. Developmental Psychology (may be child, adolescent, adult or life span)
    - 7. Psychopathology/Abnormal Psychology
    - 8. Research and Evaluation
    - 9. Career Development Counseling
    - 10. Multicultural Concerns
    - 11. Substance/Chemical Abuse
    - 12. Physiological Psychology
    - 13. Organizational Psychology
    - 14. Mental Health Consultation
    - 15. Developmentally Disabled Persons
    - 16. Abusive Relationships
    - 17. Chronically Mentally Ill

- Counseling Practicum
- Counseling Internship

### 5. MHS Qualifications

As defined in WAC 246-341-0200 (Attach supporting documentation)

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<th>Training Completion Date</th>
<th>Subject</th>
<th>Training Hours</th>
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### 6. Supervised Experience by Mental Health Professional

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### 7. Supervised Experience by Mental Health Specialist

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<th>Specialty Area</th>
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### 8. Applicant Attestation

I certify that I meet the criteria as indicated above. I have attached the required documentation regarding my education, experience, and supervision:

Signature of Applicant: _________________________     Today’s Date: ___________________________

Print Name: ________________________________