

For PD Personnel Only:

Conference #: \_\_\_\_\_

Date of Submission: \_\_\_\_\_

**MISSISSIPPI DEPARTMENT OF MENTAL HEALTH**

DIVISION OF PROFESSIONAL DEVELOPMENT

CONTINUING EDUCATION APPLICATION

Mississippi Department of Mental Health



**\*This application must be submitted no later than 60 days prior to the activity.**

**SECTION A. IDENTIFYING INFORMATION**

Title of Continuing Education Activity:

Primary Provider:

Location:

Date(s):

Number of Continuing Education Hours Requested:

Name: (Individual Submitting Forms)

Email Address:

Telephone Number:

Mailing Address:

**SECTION B. PLANNING**

Is there a registration fee?

If yes, indicate amount of fee:

Do you utilize online registration?

If yes, please include web address:

Planning Committee (Name and Professional Affiliation) List Below:


**CONTINUING EDUCATION CREDIT. (Select Yes or No to indicate desired credit)**

(DMH) Mental Health Therapist	Continuing Medical Education
(DMH) Intellectual and Developmental Disabilities (IDD) Therapist	Social Worker (MBOE)
(DMH) Licensed Administrator	Counselor/ LPC (NBCC)
(DMH) Community Support Specialist	Alcohol and Drug Counselor (NAADAC)
(DMH) Certified Peer Support Specialist	Psychologist (APA)
(DMH Addictions Therapist	Certified Health Education Specialist (CHES)

**AUDIENCE**

Indicate the number of expected participants:

Please explain how this activity will enrich the participant's contribution to quality care and pursuit of professional career goals:

Please list the overall goal(s) of this activity:

**PHYSICAL FACILITIES**

How does the facility meet ADA accommodation requirements?

How does the site accommodate teaching strategies?

Provide details on the environmental comfort:

**SECTION C. PHILOSOPHY OF SPONSOR(S)**

Is your organization affiliated with the Mississippi Department of Mental Health?

If no, please list your organization's Mission Statement:

Notes: