Hamilton County
Mental Health Recovery Services Board

HEALTH OFFICER DESIGNATION - APPLICATION

PRINT NAME_____Date _____

JOB TITLE _____

AGENCY/FACILITY_____

AGENCY ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____ E-MAIL ADDRESS _____

YEARS WITH THE AGENCY_____ YEARS WORKING WITH SMI_____

PROFESSIONAL CREDENTIALS _____ LICENSE NUMBER_____

STATE YOUR NEED FOR HEALTH OFFICER DESIGNATION IN YOUR CURRENT ROLE

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You are being asked to have senior leadership from your organization to sign off on your request to become a Health Officer. It is important to know that when signing a Statement of Belief, you are acting as an agent of your organization, not independently, and performing your duties as a Health Officer may subject you and the organization to liabilities.

PRINT NAME OF AGENCY REPRESENTATIVE_____

AGENCY REPRESENTATIVE'S SIGNATURE_____

TITLE_____

If Renewing, did you complete 3 CEU's in mental health in the past 2 years? Y◯ N◯

APPLICANT SIGNATURE_____ DATE _____

Health officer criteria revised: 3-18-25