POSTPARTUM SUPPORT INTERNATIONAL
Employment/Volunteer Verification Form for PMH-C Applicants

Employer/ Volunteer Supervisor:
You are being asked to verify employment for someone applying for Perinatal Mental Health Certification (PMH-C) by Postpartum Support International (PSI). Please complete all sections of this form and **return it to the applicant** to be included in the application portfolio. If you have questions, please contact PSI at certification@postpartum.net.

Applicant:
Submit only as many forms as needed to verify the required 2 years of post-graduate/post-certificate experience. Duplication of the form is acceptable if more than one organization is completing the form.

Name of Applicant: _____

PMH-C Track: (Check one)
- ☐ Mental Health/Psychotherapy
- ☐ Psychopharmacology
- ☐ Affiliated Professional

Name of Facility/Company/Organization: _____

Applicant's Role/Title in Organization: _____

City, State/Province, and Country: _____

Applicant Start Date: _____ Applicant End Date: _____

Employment Type:
- ☐ Full-time
- ☐ Part-time (%FTE = _____)
- ☐ Contractor/1099 employee (_____ hours/annually)
- ☐ Volunteer Experience (_____ hours/week)

Name of Person Signing the Form _____

Job Title _____

Email Address _____

Phone Number _____

Signature _____

Date Completed _____

POSTPARTUM SUPPORT INTERNATIONAL
Private Practice (PP) Attestation Form for *Self-Employed* PMH-C Applicants

I, _____(applicant) am applying for Postpartum Support International's Certification in Perinatal Mental Health (PMH-C). I understand that one of the requirements is completing at least two years of full-time experience post-graduation, with some experience working with the perinatal population. By completing this form and signing below, I hereby certify that I meet this minimum work requirement in my own private practice that I own.

PMH-C Track: (Check one)
- ☐ Mental Health/Psychotherapy
- ☐ Psychopharmacology
- ☐ Affiliated Professional

Please provide information about relevant work experience (prior positions, information about your private practice including: the current population you serve, training, areas of expertise, modalities used, etc.)

Name of Applicant _____

Name of Private Practice _____

Years in Private Practice **(include start date)** _____ years, From ____/____/_____ to ____/____/_____

PP Address: _____

PP Website: _____

Applicant Signature _____

Date Completed _____