



Mental Health Rehabilitation Specialist Verification Form

Email to HS_BHRS_QM@smcgov.org or fax 650-525-1762

Name: _____

Agency: _____

Address: _____

Phone & Email: _____

Education (choose all that apply):

Associate's Degree: Major: _____ Bachelor's Degree: Major: _____
 Graduate Degree or two years of graduate education: Social Work (MSW) Marriage and
 Family Therapy (MFT) Clinical Counseling (LPCC) Psychology (PhD/PsyD)
 Other (specify) _____

Experience: ** Experience must be PROVIDING DIRECT CLIENT SERVICES in the fields of physical restoration, social adjustment, or vocational adjustment within a mental health setting.

Experience in Mental Health field: Yes No

How many years of post-AA degree experience in a mental health setting?

0-1 year 2-3 years 4-5 years 6 years or more

YOU MUST HAVE combined 8 years of education and mental health experience.

Describe experience (include agency(s) and length of time at agency(s)):

MHRS Applicant Signature: _____ Date: _____

Signature of Supervisor verifying that all the above information is accurate and true.

Signature of Supervisor: _____ Date: _____