Mental Health Integrative Medicine Institute

Application for Certified Mental Health Integrative Medicine Provider (CMHIMP)

Date:

Name:_____

Address:_____

City/State/Zip/Country:_____

Phone:(_____)_____

Email Address:_____

I attest to the following (please initial each):

____I have completed the required 18 education hours of Nutrition & Integrative Medicine for Mental Health.

____I have conducted at least 20 sessions with clients in which nutritional and integrative medicine approaches were discussed as part of a comprehensive treatment plan.

I verify that this application is complete, accurate, and that the information provided and attested to is factual and true. I understand that if any of the information provided and attested to is false or found to be false, my certification will be denied and/or revoked, and my licensing board may be contacted. I understand that information submitted with this application may be verified for accuracy by the Mental Health Integrative Medicine Institute. I also agree to contact the Mental Health Integrative Medicine Institute in the event that I no longer meet the requirements to be a Certified Mental Health Integrative Medicine Provider.

Signed:

Date: