



Screener Application

Applicant's Name

Date of Application

Address

City

State

Zip Code

E-Mail Address

Phone Number

Education

| | Name and Location | Degree Diploma | Major |
|--------------------|-------------------|-------------------|-------|
| High School | | | |
| College/University | | | |
| Graduate School | | | |
| Technical Training | | | |
| Other | | | |

Professional License/Certification

List any Professional Licenses you hold with its corresponding information.

| License/Certification | Number | State(s) | Expiration Date |
|-----------------------|--------|----------|-----------------|
| | | | |
| | | | |
| | | | |

Have you ever had your license suspended/revoked? _____ Yes _____ No

If yes, please explain _____

Have you ever received any disciplinary action from a licensing or certification board? _____ Yes _____ No

If yes, please explain _____

Unlicensed mental health professionals who meet the requirements to be a credentialed mental health screener are required to work under the direct supervision of a practicing Psychiatrist.

Psychiatrist's Name

DE License Number

Employer

Employment History

| Date | Employer Name & Address | Position & Duties |
|--------------|-------------------------|-------------------|
| From: To: | | |

Do you have any pending criminal charges against you? _____ Yes _____ No
 Have you ever been convicted of a misdemeanor or felony offense? _____ Yes _____ No

If you answered yes to either of the above inquiries, please provide the date and city and state of the pending charge or conviction, the type of charge or conviction, and an explanation. (An affirmative answer does not automatically bar you from the application process). _____

I certify that my answers are true and complete to the best of my knowledge.

 Applicant Signature

 Date

Please scan and email to annmarie.lavelle@delaware.gov or fax to Ann-Marie Lavelle at 302-255-9952