The Infant-Parent Mental Health Post-Graduate Certificate Program

CHILD DEVELOPMENT UNIT
CHILDREN'S HOSPITAL
BOSTON

DR. ED TRONICK
University Distinguished Professor
University of Massachusetts Boston
Director of the Child Development Unit Children's Hospital Harvard Medical School, Boston

UNIVERSITY OF MASSACHUSETTS BOSTON
Departments of Psychology & Corporate, Continuing & Distance Education

DR. DOROTHY RICHARDSON
Program Director
Infant-Parent Mental Health
Post Graduate Certificate Program

2010-2011 Program offered at the University of Massachusetts, Boston

APPLICATION FOR PROGRAM ADMISSION FOR 2010-2011
PROGRAM TUITION: $7,500
APPLICATION FEE: $50*
*CHECK MADE OUT TO UNIVERSITY OF MASSACHUSETTS

Personal Data

Name: _____
First *Middle* *Last*

Other names that may appear on credentials: _____

Preferred Mailing Address: _____
Street Address

_____
City *State* *Zip*

Residence Address (only if different from above): _____
Street Address

_____
City *State* *Zip*

Home Phone: _____ Work Phone: _____
Cellphone: _____ Fax: _____
E-Mail Address: _____ Pager: _____

Educational Data - Use chronological order starting with most recent. ATTACH COPIES OF GRADUATE SCHOOL TRANSCRIPT

Name of College or University:	City & State	Units Completed	Major	Graduation Date	Degree Received

Professional License and/or Credential Data - ATTACH A PHOTOCOPY OF EACH LICENSE & CREDENTIAL

Type of License or Credential	Issuing State Board or Professional Organization	License or Credential #	Effective Date	Expiration Date

Employment Data - **List employment that totals at least 2 years of work experience with children age 0-5. It is not necessary to list employment beyond that needed to show the 2 years of work experience.**

Employer (list "self" if applicable)	
Employment Address	
Employment title or job (role)	
Date you started this employment	
Date employment ended (if applicable)	
Hours per week typically worked	
Typical percent of time dedicated to serving children age 0-5 and their families	
Briefly describe your work in this setting:	

It is not necessary to list employment beyond that needed to show 2 years of work experience with children 0-5.

Employer (list "self" if applicable)	
Employment Address	
Employment title or job (role)	
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Employment Address	
Employment title or job (role)	
Date you started this employment	
Date employment ended (if applicable)	
Hours per week typically worked	
Typical percent of time dedicated to serving children age 0-5 and their families	
Briefly describe your work in this setting:	

Use additional sheets, if needed.

Statement of Interest - Briefly describe your interest in the infant-parent mental health field and the relevance of this course of study to your work with children and families **(no more than 100 words)**:

Diversity - For purposes of this IPMHFP, "diversity" will be construed as encompassing: values, beliefs, practices, age, gender, sexual orientation, ethnicity, race, class, country or place or origin, religious and spiritual beliefs, physical characteristics and attributes, motor abilities, cognitive ability, socio-economic status, living location and situation, communication abilities (e.g. speaking and reading), functional challenges, family constellation, and other perceived differences. Each individual and family has a unique experience and expression of culture, and no single element or variable can be generalized to describe the cultural experience and expression of any group or individual (e.g. Hispanics, women, special needs, etc.). Given this definition, briefly describe the range of diversity in the children you serve age 0-5 and their families and how your work reflects awareness of cultural differences **(no more than 100 words)**:

A. Indicate the discipline(s) in which you are licensed, certified and/or credentialed. Check all that apply:

- ☐ Occupational therapist
- ☐ Physical therapist
- ☐ Physician
- ☐ Nurse
- ☐ Psychologist
- ☐ Social worker/LCSW
- ☐ Marriage & family therapist
- ☐ Educator
- ☐ Speech/Language
- ☐ Dietician
- ☐ Other, please list: _____

B. Indicate the type of practice setting(s) you work in. Check all that apply:

- ☐ Private/not-for-profit agency
- ☐ Public school system
- ☐ Private school
- ☐ Private practice
- ☐ Community clinic
- ☐ Kaiser
- ☐ Public or governmental agency
- ☐ Hospital
- ☐ Child Care
- ☐ Self-employed
- ☐ Other, please list: _____

C. Estimate the *PERCENT* of your time in a typical workweek spent in the following activities:

Direct services	Supervising Staff	Administering Programs	Training	Influencing Public Policy	Other/List	= Total
_____	_____	_____	_____	_____	_____	= 100%

D. When performing the activities in "C" (above), estimate the *PERCENT* of your time in a typical workweek spent serving or performing activities for children of the following ages or their parents:

Prenatal	Birth to 12 months	12 to 24 months	24 to 36 months	36 to 48 months	48 to 60 months	Other	= Total
_____	_____	_____	_____	_____	_____	_____	= 100%

E. When performing the activities in "C" (above), estimate the *PERCENT* of your time in a typical workweek spent serving or performing activities in the following areas for children 0-5 or their parents:

Preventive Services	Screening	Early intervention	Formal Assessments	Assessment-driven Therapy	Other/ List	= Total
_____	_____	_____	_____	_____	_____	= 100%

Application Checklist –

1. _____ YOUR INITIALS — I understand that upon acceptance to the program a $4,000 deposit will be due. I understand that half of this deposit ($2,000) can be returned to me if I provide written notice to the program (as described in my letter of acceptance) that is received by 3pm on July 1, 2010 that I wish to withdraw my enrollment from the program. If notification of withdrawal is received after that date, I will receive no reimbursement of any portion of my tuition and fees.

2. _____ YOUR INITIALS — I understand that my full tuition and fees of $7,500 are due by August 2, 2010.

3. _____ YOUR INITIALS — I have reviewed the course training dates. I understand that missing more than 24 hours of course time or missing any mandatory training will result in me not being eligible for my certificate of completion.

4. _____ YOUR INITIALS — I understand that I must show evidence of completing a 3-unit course in infant/child development, developmental psychology, human development or similar course in order to complete the IPMHPCP. [If you have already met this requirement, attach a photocopy of the transcript for verification (a certified copy is not needed), or attach a page to this application outlining your plan for completing this course requirement by March 2011.]

5. _____ YOUR INITIALS — I understand that my letter of completion from the University of Massachusetts Boston for the Infant-Parent Mental Health Post-Graduate Certificate Program will be provided only after I have completed all course requirements on the timeline explained in the program description.

6. _____ YOUR INITIALS — I have read the program description packet, including the information entitled "Responsibility of Trainees," and I understand and agree to my responsibilities.

7. _____ YOUR INITIALS — I understand that no promises or guarantees are expressed or implied regarding employment, career advancement, licensing, credentialing, endorsement, or graduate units based on the completion of the IPMHPCP.

8. _____ YOUR INITIALS — I understand that while I am attending the IPMHPCP, completing course assignments, completing practicum/integration hours, meetings with colleagues, and in all other activities related to the IPMHPCP, I will not be covered by any student insurance, liability insurance or coverage, malpractice insurance or coverage, or other insurance held by the University of Massachusetts Boston, or any other sponsor, partner or faculty. Further, I agree to hold these entities harmless in the event of any accident, illness, or injury to or by me, or in any legal action against me arising from my activities while participating in the IPMHFP. I understand that I am solely responsible for my professional actions and decisions in all activities associated with the IPMHPCP, and that I am solely responsible for practicing within the licensing, credentialing, code of ethics, and professional scope of my profession

9. _____ YOUR INITIALS — I understand that the purpose of the IPMHPCP is to increase the number of providers willing and trained to provide infant-parent mental health service for children age 0-5, their families and other caregivers, and for pregnant women. To the extent possible, I commit to continue to work with the 0-5 population throughout the IPMHFP and for at least 1 year after completing the training.

10. _____ YOUR INITIALS — I consent to listing my name, mailing address, phone numbers, e-mail address, my discipline, work setting, and degree on a class roster that may be distributed to class members, mentors, faculty, and guest speakers either in electronic or hardcopy format.

I hereby state that the above information is true and correct and I request admission to the Infant Parent Mental Health Post-Graduate Certificate Program. I agree to the conditions and responsibilities, as described.

Printed Name	*Signature*	*Date*

Mail completed applications with $50 application fee made out to "University of Massachusetts" to:	**UMB IPMHPCP** **Attn: Dorothy Richardson, Ph.D** **1758 Beacon Street, Suite # 1** **Brookline, MA 02445**

Please be sure to include a copy of your transcripts and your license(s) and/or credential(s) as noted on page 1. Applications will not be processes without these documents.

IMPORTANT:

Please call or email five (5) days after mailing your application to assure it was received.
Please make a complete copy of your application before submission.

FOR ADDITIONAL INFORMATION, PLEASE CONTACT:

Program Coordinator, Randell Dauda: Randell.Dauda@childrens.harvard.edu
Program Director, Dr Dorothy Richardson: dorothy@dtrichardson.com
Or call: 617-232-3916