Please Email Registration to: MPA.Info@tn.gov

REGISTRATION
MANDATORY PRE-SCREENING AGENT TRAINING
Please Print

Requested Training Date (see training announcement for dates) _____

Are you taking the initial training to satisfy MPA recertification requirements? Yes □ No □

Name (as listed on your license): _____

Agency (if applicable): _____

Business Address: _____

Business Phone: (_____) _____

Business E-mail: _____

Home Address: _____

Home Phone: (_____) _____

Home E-mail: _____

Why are you interested in becoming designated as a MPA?

_____

Are you employed full---Time or part---time by a TDMHSAS contracted crisis provider? Yes □ No □

I am a (check all that apply):

❒	**Licensed physician with training, education, or experience in psychiatry**	**Expiration date:** _____
❒	**Licensed psychologist designated as a health service provider**	**Expiration date:** _____
❒	**Licensed psychological examiner**	**Expiration date:** _____
❒	**Licensed senior psychological examiner**	**Expiration date:** _____
❒	**Licensed master social worker (LMSW) with two years of mental health experience* (sign statement below)**	**Expiration date:** _____
❒	**Licensed clinical social worker**	**Expiration date:** _____
❒	**Licensed or certified marital and family therapist**	**Expiration date:** _____
❒	**Licensed nurse with a masters degree in nursing who functions as a psychiatric nurse**	**Expiration date:** _____
❒	**Licensed professional counselor**	**Expiration date:** _____
❒	**Licensed Physician's Asst. with a master's degree & expertise in psychiatry as determined by training, education or experience**	**Expiration date:** _____

*** As a licensed master social worker, I affirm that I have two (2) years of mental health experience.** _____ **LMSW Signature**

Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____
(Supervisor's signature is mandatory)

Revised August 2019