



MISSISSIPPI STATE DEPARTMENT OF HEALTH

Experience Verification Form for Grandfather (Transitional) Pathway

Purpose and Instructions

The Bureau of Professional Licensure with the Mississippi State Department of Health (MSDH) certifies Community Health Workers (CHW) who have demonstrated proficiency as a CHW before January 1, 2026, and are eligible to apply with the Grandfather (Transitional) Pathway. This form is intended to verify the applicant listed in Section 1 below meets certification requirements based on experience. One form is required per reference.

To qualify for the Grandfather (Transitional) Pathway, [Certified Community Health Worker Regulations](#) requires an applicant to demonstrate CHW practice before January 1, 2026, have a minimum of 2,000 hours of CHW work, and have two (2) references from both a supervisor/ employer and a community partner.

Applicants are required to provide this form to each reference (one supervisor/employer and one community partner) who can verify their experience within the last five (5) years prior to January 1, 2026. The selected reference must complete and email this form to the Department at MSDHProfLicensure@msdh.ms.gov or mail the completed form directly to our office. MSDH will NOT accept an Experience Verification Form submitted directly by the applicant.

Contact Information

For questions or more information, please review the [Certified Community Health Worker Regulations](#). You may contact the Department by phone at (601) 364-7360 or email MSDHProfLicensure@msdh.ms.gov.

Section 1

This section must be completed by the applicant. The information provided must match the application.

Name: _____
(First) (Middle) (Last)

Date of Birth: ____-____-____
(month) (day) (year)

Phone Number: _____

Email Address: _____

Section 2

This section must be completed by the supervisor/employer or community partner.

Name: _____
(First) (Middle) (Last)

Title: _____

Business Name: _____

Business/Contact Phone Number: _____

Business Address: _____
(Street)

(City) (State) (Zip Code) (County)

Email Address: _____

Section 3

This section must be completed by the supervisor/employer or community partner.

Position Information

Applicant's Position/Role: _____

Start Date: ____ - ____ - ____
(month) (day) (year)

End Date: ____ - ____ - ____
(month) (day) (year)

Type of Experience

- ☐ Experience obtained from full-time employment
- ☐ Experience obtained from part-time employment
- ☐ Experience obtained from volunteering

CHW Core Competencies (which include skills, knowledge, and qualities) achieved and demonstrated from Rule 15.1.3. Select all that apply:

- ☐ Communication
- ☐ Use of public health concepts and approaches
- ☐ Organizational and community outreach
- ☐ Advocacy and community capacity building
- ☐ Care coordination and system navigation
- ☐ Health coaching
- ☐ Documentation, reporting, and outcome management
- ☐ Legal, ethical, and professional conduct

Did the applicant achieve at least 2,000 hours of CHW work in this position?

- ☐ Yes
- ☐ No

If no, how many hours of total CHW work did the applicant achieve? _____

Section 5

This section must be completed by the supervisor/employer or community partner.

I certify that all of the information provided on this form is true and complete per my knowledge. I understand that providing false or misleading information is a violation of professional and ethical standards. A violation will result in an application being voided and/or the certification of an applicant being revoked. The false or misleading information may also result in criminal prosecution for tampering with a governmental record.

Signature: _____

Date Signed: _____

Email completed form to MSDHProfLicensure@msdh.ms.gov OR mail to:

**MSDH – Professional Licensure
PO Box 1700
Jackson, MS 39215**