MISSISSIPPI STATE DEPARTMENT OF HEALTH

Community Health Worker Certification Application

Thank you for your interest in applying to become a Certified Community Health Worker. Submission of an application does not guarantee Certified Community Health Worker status. Applicants will receive a notification from the Bureau of Professional Licensure regarding approval or denial of the application. Applications may take up to thirty (30) days to process once all documents have been submitted.

The following items are required to submit a complete application:

1. Passport-styled photograph (2x2 inch, forward-facing) headshot, plain white background
2. Copy of current driver's license or social security card
3. Copy of diploma or GED certificate
4. MSDH Comprehensive Background Check - 21489.pdf
5. Proof of eligibility as specified by application type:
    a. Training Pathway
    b. Experience Pathway
    c. Endorsement/Reciprocity Pathway
    d. Grandfather (Transitional) Pathway – application must be submitted before December 31, 2027 to apply for grandfathering
6. Application Fee of $40.00 (non-refundable - check or money order made payable to MSDH; cash is **not** accepted)

Personal Information

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

Home Address: _____
(Street)

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

Email Address: _____

Phone Number: _____

Social Security Number: _____

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

Education (select one)

- ☐ High School Diploma or GED certificate
- ☐ Some college, no degree
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Post-graduate Degree

Eligibility Pathway (select one)

Please refer to Rule 15.2.1 for information regarding Eligibility Pathways:
Certified Community Health Worker Regulations

- ☐ Training Pathway
- ☐ Experience Pathway
- ☐ Endorsement/Reciprocity Pathway
- ☐ Grandfather (Transitional Pathway)

Employment History – please include your last five (5) years of employment history. Start from your most recent (or current) place of employment

Place of Employment: _____

Job Title: _____ **Supervisor Name:** _____

Supervisor Email Address: _____

Employment Address: _____
(Street)

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

Start Date: _____

End Date: _____

Please use "Additional Employment History" page if needed.

Attestation – Please read each statement and sign your initials.

I attest that I have read the MSDH CHW Training Manual in its entirety. _____

I attest that all of the information provided in this document is true and complete. I understand that providing false or misleading information may result in the denial, suspension, or revocation of certification. _____

I understand that the application and all supporting documentation become the property of the Bureau of Professional Licensure and are not returnable. _____

I agree to abide by the rules and regulations regarding the training and certification of Community Health Workers. _____

I acknowledge that I have read, reviewed, and understand the Community Health Worker Code of Ethics. _____

I will report any changes in my contact information to the Bureau of Professional Licensure. _____

Applicant Name: _____

Applicant Signature: _____ Date: _____

Additional Employment History

Place of Employment: _____

Job Title: _____ **Supervisor Name:** _____

Supervisor Email Address: _____

Employment Address: _____
(Street)

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

Start Date: _____

End Date: _____

Place of Employment: _____

Job Title: _____ **Supervisor Name:** _____

Supervisor Email Address: _____

Employment Address: _____
(Street)

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

Start Date: _____

End Date: _____