



Application for Certification Examination for Equine Interaction Professionals (Mental Health)

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See examples provided. →

A	B	C	1	2	3
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Correct:
 Incorrect:

Candidate Information

Mr. Mrs. Ms. Dr.
 First Name Middle Initial

Last Name Suffix (Jr., Sr., etc.)

Number and Street Apartment Number

City State/Province Zip/Postal Code

Daytime Phone: - -
 Evening Phone: - -

Email Address

Certification

A. FOR WHICH CERTIFICATION ARE YOU APPLYING? CEIP - Mental Health

B. HAVE YOU TAKEN THIS EXAMINATION BEFORE?
 No Yes *If yes, indicate month, year, and name under which the examination was taken.*
 Date (month/year): _____
 Name: _____

C. HAVE YOU EVER BEEN CERTIFIED AS A CEIP BY CBEIP?
 No Yes *If yes, please provide your most recent CEIP Certificate Number and Expiration Date (Attach copy of certificate)*
 Certificate Number:
 Expiration Year / Month: /

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

D. CURRENT PROFESSION (*darken only one response*)

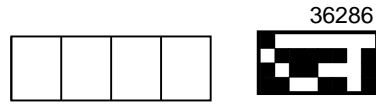
- Mental Health Counselor (Professional/Clinical)
- Clinical Social Worker
- Marriage and Family Therapist
- Psychologist (Clinical/Counseling)
- Psychiatrist
- Psychiatric-Mental Health Nurse Practitioner
- Other
(please describe) _____

E. List your professional memberships:

F. HIGHEST ACADEMIC LEVEL ACHIEVED:

- Bachelor's Degree
- Master's Degree
- Doctorate

(Continue on page 2)





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Eligibility and Background Information

G. YEARS OF PRACTICE WITH HORSES OR OTHER EQUINES:

- 3 - 5 years
- 6 - 10 years
- More than 10 years

H. HOURS PER WEEK OF THERAPY PRACTICE INCORPORATING HORSES

- 0 - 1 hour/week
- 2 - 5 hours/week
- 6 - 10 hours/week
- 11 - 15 hours/week
- 16 - 24 hours/week
- More than 24 hours/week

I. PRIMARY CLIENT POPULATION YOU WORK WITH:

- Children
- Adolescents
- Adults
- Families
- Other: _____

J. PRIMARY CLIENT CHALLENGES:

- Trauma
- Addiction/Substance Use
- Neuropsychiatric Disorders (ASD,ADHD,etc.)
- Anxiety
- Depression
- Developmental/Intellectual Delay
- Other

K. HOURS OF COURSES/TRAINING:

Total Education/Training Hours from Page 3 Enter whole numbers only

L. NUMBER OF HOURS OF EXPERIENCE:

Total Professional Experience Hours from Page 3 Enter whole numbers only

Equine Interaction Client Hours from Page 3 Enter whole numbers only

M. HAVE YOU EVER OWNED/CARED FOR A HORSE?

- No Yes

N. HAVE YOU EVER RECEIVED FORMAL RIDING, HORSEMANSHIP OR EQUINE BEHAVIOR INSTRUCTION?

- No Yes

O. DO YOU HAVE ANY RECOGNIZED CREDENTIALS IN EQUINE BEHAVIOR, CARE AND MANAGEMENT, OR RIDING?

- No Yes If yes, what are they? _____

P. HAS YOUR LICENSE EVER BEEN REVOKED OR RESCINDED?

- No Yes If yes, please attach an explanatory statement.

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your certification.

Race	Age Range:	Gender:
<input type="radio"/> African American	<input type="radio"/> Under 25	<input type="radio"/> 40 to 49
<input type="radio"/> Asian	<input type="radio"/> 25 to 29	<input type="radio"/> 50 to 59
<input type="radio"/> Hispanic	<input type="radio"/> 30 to 39	<input type="radio"/> 60+
<input type="radio"/> Native American	<input type="radio"/> 40 to 49	<input type="radio"/> Male
<input type="radio"/> White	<input type="radio"/> 50 to 59	<input type="radio"/> Female
<input type="radio"/> No Response	<input type="radio"/> 60+	

Candidate Signature (Please fill all three pages of this application before signing below)

I have read the Handbook for Candidates and understand I am responsible for knowing it's contents. I certify that the information given in this Application is in accordance with Handbook instructions and is accurate, correct, and complete.

CANDIDATE SIGNATURE: _____ **DATE:** _____

Payment for certifications should be made online at the CBEIP.org website at:

<https://www.cbeip.org/check-out/>

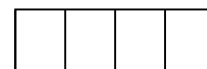
FOR OFFICE USE ONLY

Date

Fee:

CC Check

36286





Application for Certification Examinations for Equine Interaction Professionals *(Mental Health)*

Please fill these tables and sign at the bottom of the page.

Direct facilitation training in equine interaction work <i>(min. 40 hours – attach proof of training)</i>			
Date	Course/Training	Presenter/Organizer	Hours
Total Hours:			
Attendance at equine interaction conference, workshop, or method training <i>(min. 40 hours - attach proof of attendance)</i>			
Date	Course/Training	Presenter/Organizer	Hours
Total Hours:			
Formal training in equine behavior/horsemanship <i>(min. 40 hours - attach proof of training)</i>			
Date	Course/Training	Presenter/Organizer	Hours
Total Hours:			
Professional Experience <i>(min. 3 years of professional service - full time equivalent experience)</i>			
Date	Employer	Location	Hours
Total Hours:			
Delivery of equine interaction client services <i>(min. 300 hours)</i>			
Date	Employer	Location	Hours
Total Hours:			

I certify that the information given in this Application is in accordance with Handbook instructions and is accurate, correct, and complete.

Candidate Signature: _____ Date: _____

Print name: _____