**KENT & MEDWAY APPROVED MENTAL HEALTH PROFESSIONAL**

**APPROVAL PANEL**

**APPLICATION FOR TRANSFER OF AMHP APPROVAL**

**INFORMATION REQUIRED FROM AMHP’S PREVIOUS APPROVED BY A LOCAL SOCIAL SERVUCES AUTHORITY**

**Please complete to assist the AMHP’s approval by Kent County Council or Medway Council**

**1) NAME OF AMHP:**

**2) NAME OF LOCAL SOCIAL SERVICES AUTHORITY PROVIDING INFORMATION:**

**3) HCPC APPROVED AMHP TRAINING PROGRAMME**

Name of Programme:

Number of formal training days (including practice learning):

Date completed:

**4) AMHP’S FIRST APPROVAL**

Local Social Services Authority:

Dates of Approval: From:

 Until:

**5) REAPPROVAL - IF ANY:**

Local Authority: Date from: Until:

**6) AMHP REFRESHER TRAINING ATTENDED SINCE**

**LAST APPROVED/REAPPROVED:**

Name of programme(s) attended:

Number of whole training days:

Dates attended:

**7) AMHP PRACTICE ACTIVITY OVER LAST 12 MONTHS:**

 is the AMHP currently appointed as such by this Local Social Services Authority?

YES/NO

Has the AMHP actually been undertaking MH Act duties over this period?

 YES/NO

Average number of MH Act assessments undertaken by the AMHP per month:

**8) AMHP QUALITY STANDARDS**

Name of AMHP’s most recent AMHP practice supervisor:

Does the practice supervisor consider that the quality of the AMHP’s MH Act practice has satisfactorily meet all the standards of competence set out in Schedule 2 to The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 for AMHP training and practice?

 YES/SOME/NO

If some practice standards have not been met satisfactorily, which are the competences which this practice supervisor considers should be (re)assessed?

**9) ANY OTHER INFORMATION KNOWN TO THE LOCAL SOCIAL SERVICES**

**AUTHORITY WHICH IS RELEVANT TO CONSIDERATION FOR APPROVING**

**THIS AMHP:**

**10) SIGNED ON BEHALF OF THE LOCAL SOCIAL SERVICES AUTHORITY:**

PLEASE PRINT FULL NAME AND POSITION:

DATE:

**MANY THANKS FOR YOUR CO-OPERATION.**