First 5 Alabama®

Alabama Association for Infant and Early Childhood Mental Health

The Alabama Association for Infant and Early Childhood Mental Health (AAIECMH) was formed in January 2017 and will operate under the name of *First 5 Alabama*. During this time, the AAIECMH became a licensed affiliate of the Alliance for the Advancement of Infant Mental Health®, a global organization that includes those states and countries whose infant mental health associations have licensed the use of the Competency Guidelines® and Endorsement® for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® under their associations' names.

Purpose and goals of the Association:

- to promote throughout Alabama, the healthy social, emotional, cognitive, and physical development of young children through supportive and nurturing relationships from conception through five years of age;
- to facilitate interdisciplinary cooperation among individuals concerned with promoting conditions that will bring about the optimal development of young children and child-caregiver and child-parent relationships;
- to encourage the realization that early childhood is a sensitive period in the psychosocial development of individuals;
- to promote education, research, and study of the effects of mental development during early childhood on later social/emotional/behavioral and psychopathological development;
- to promote education, professional development, and expertise of a cadre of professionals concerning the mental health of young children, parents, families and other caregivers of young children;
- and to promote the development of scientifically based and/or informed programs of care, promotion, intervention, and prevention of mental impairment in early childhood.

Who should join? Anyone interested in the healthy development of children pre-birth to age five.

Association membership is also required for those seeking one of the four categories of Endorsement® appropriate for practitioners, teachers, counselors, and leaders in the early childhood and mental health fields. Association members get advance notice and first opportunity in training and professional development opportunities and activities of the Association.

Regular Membership

☐1 Year Association Dues $25.00 (Professional)
☐1 Year Association Dues $15.00 (Student)
☐1 Year Association Dues $10.00 (Parent)

☐1 Year Agency Membership (up to 10 staff) $250
☐1 Year Agency Membership (up to 15 staff) $375
☐1 Year Agency Membership (up to 20 staff) $500

Last Name:____________________ First Name:____________________

Title:____

Agency or Organization: ____

Address:______________________ City:_______________ZIP: ________

Email:____________________________Phone: ______________________

Current Discipline or Expertise:

	Early Childhood
	EI Provider
	Higher Ed/School
	Mental Health Professional
	Nurse
	OT or PT
	Parent
	Physician
	Social Worker
	Other:

Checks should be made payable to the **Alabama Partnership for Children** and mailed to:

Alabama Partnership for Children
Attn: AAIECMH *First 5 Alabama*
2595 Bell Road
Montgomery, Alabama 36117

Association use only:

Payment: Cash Receipts: ____________ Check #:______________

Documentation: Spreadsheet:_____________ Welcome Letter:________ Assoc. #:______________

Member 2

Last Name:______________________ First Name:______________________

Title:____

Agency or Organization: ____

Address:________________________ City:________________ZIP: ________

Email:______________________________Phone: _______________________

Association use only:

Assoc. #:______________

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	Nurse
	OT or PT
	Parent
	Physician
	Social Worker
	Other:

Member 3

Last Name:______________________ First Name:______________________

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Agency or Organization: ____

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Email:______________________________Phone: _______________________

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	Parent
	Physician
	Social Worker
	Other:

Member 4

Last Name:______________________ First Name:______________________

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	Parent
	Physician
	Social Worker
	Other:

Member 5

Last Name:______________________ First Name:______________________

Title:____

Agency or Organization: ____

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Email:______________________________Phone: _______________________

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	Other:

Member 6

Last Name:____________________ First Name:____________________

Title:____

Agency or Organization: ____

Address:______________________ City:______________ZIP: _______

Email:___________________________Phone: _____________________

Association use only:

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	Physician
	Social Worker
	Other:

Member 7

Last Name:____________________ First Name:____________________

Title:____

Agency or Organization: ____

Address:______________________ City:______________ZIP: _______

Email:___________________________Phone: _____________________

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Member 8

Last Name:____________________ First Name:____________________

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Member 9

Last Name:____________________ First Name:____________________

Title:____

Agency or Organization: ____

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Member 10

Last Name:______________________ First Name:______________________

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	Other:

Member 11

Last Name:______________________ First Name:______________________

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Agency or Organization: ____

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Member 12

Last Name:______________________ First Name:______________________

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Member 13

Last Name:______________________ First Name:______________________

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Member 14

Last Name:_____________________ First Name:_____________________

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Member 15

Last Name:_____________________ First Name:_____________________

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Member 16

Last Name:_____________________ First Name:_____________________

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Member 17

Last Name:_____________________ First Name:_____________________

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Member 18

Last Name:_____________________ First Name:_____________________

Title:____

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	Other:

Member 19

Last Name:_____________________ First Name:_____________________

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Agency or Organization: ____

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Email:_____________________________Phone: _______________________

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Member 20

Last Name:_____________________ First Name:_____________________

Title:____

Agency or Organization: ____

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Email:_____________________________Phone: _______________________

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