

Associated Employee Assistance Services EAP Affiliate Application

Background information- Practitioner

First Name	Middle Name	Last Name
Tax ID / EIN/ SSN	Years in Practice	Gender M/F
License Information Type/ State/ License Number		
CEAP Certification?	Alcohol & Drug Certification?	
Education-Highest Degree	Degree School	

Practice Information- Clinic/ Office

Clinic Name	
Clinic Address	Billing Address
Primary Phone Number	Billing Phone
Emergency phone number/ pager	
Fax number	
E-mail address	
Office Contact person	
Is office handicap accessible?	

Liability Insurance

Name of Liability Carrier	Policy Number	Effective date	Expires
\$Limit per occurrence	\$Limit aggregate		

Disclosure Yes/ No

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|---|-----|----|
| 1. Have you ever been convicted of a misdemeanor related to your professional functions? | Yes | No |
| 2. Have you ever been charged or convicted of a felony in any State? | Yes | No |
| 3. Have you ever been investigated by any professional or licensure board, professional association, private payer, state or federal regulatory agency or other authority? | Yes | No |
| 4. Has your clinical license , certification or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, placed on probation or limited in any way by a licensing agency or other regulatory body? | Yes | No |
| 5. Have you ever voluntarily relinquished your license, certification or authority to practice for any reason including as an alternative to disciplinary action? | Yes | No |
| 6. Are you aware of any formal disciplinary or criminal charges pending against you? | Yes | No |
| 7. Are you aware of any complaints against you filed with any licensing, certification or other regulatory body? | Yes | No |
| 8. Has it ever been determined that you have operated outside the recognized boundaries of your professional competencies? | Yes | No |
| 9. Has your employment, EAP participation or other privileges or participation status ever been denied, restricted, suspended, reduced, revoked, not renewed, placed on probation or otherwise limited in any way? | Yes | No |
| 10. Have you ever been involuntarily terminated from professional employment by an organization that granted you privileges or participation status? | Yes | No |
| 11. Have you ever resigned with knowledge of an investigation about you by a professional employer that granted you privileges or participation status? | Yes | No |
| 12. Are you aware of any disciplinary actions against you by a professional employer that granted you privileges or participation status? | Yes | No |
| 13. Are you aware of any complaints against you filed with a professional employers who granted you privileges or participation status? | Yes | No |
| 14. Are you now or have you ever been sanctioned or excluded from federal state or local government programs including but not limited to Medicare and Medicaid? | Yes | No |

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|---|-----|----|
| 15. Have you ever been expelled from or disciplined by any professional organization or association not included in any other question? | Yes | No |
| 16. Have any malpractice suits, professional liability suits or arbitration or other proceedings ever been instituted against you? | Yes | No |
| 17. Has a professional liability carrier ever denied, limited, not renewed or cancelled your coverage? | Yes | No |

Professional Experience

Are you trained/ experienced in providing Critical Incident and Trauma Response Services? Yes No

If so, describe the training model.

Do you meet the qualifications of a Substance Abuse Professional under the Department of Transportation regulations? Yes No

If so, explain your experience and include documentation of training and test completed. Yes No

Areas of counseling interest/expertise _____

EAP Experience

I have experience providing Employee Assistance Counseling. Yes No

Total years of EAP experience _____

I am qualified to provide general assessments, short term solution focused counseling, and referrals. Yes No

I am experienced in identifying and resolving workplace problems that may be caused or exacerbated by an employee's personal or work life. Yes No

I am experienced in helping employees resolve conflict at work. Yes No

I have experience and understanding of dual client relationships. (Employee/ Employer) Yes No

I have knowledge and experience in assessing and managing high risk situations (suicide, self injury). Yes No

I have knowledge and experience in providing assessments to employees who have tested positive for substance abuse. Yes No

Availability

Are you able to return phone calls within 24 hours? Yes No

Are you able to offer an appointment within 2 business days? Yes No

Are you able to offer an urgent appointment within the same day? Yes No

I certify that all information provided in this application is true and correct to the best of my knowledge and belief. I authorize Associated Employee Assistance Services to verify my license, malpractice coverage, highest degree, as well as additional information included in this application, with all appropriate issuing organizations. I understand that filling out this application does not mean that I will be accepted in the Associated Employee Assistance Program affiliate network.

Applicant name

Applicant Signature

Date

Please return this printed application along with the following information

- Certificate of insurance and copy of license
- Completed W-9 form
- Clinic brochure and business card.

To: Associated Employee Assistance Services
 1820 Post Road, Suite 5
 Plover WI 54467
 FAX: 715-342-2058