EAP AFFILIATE APPLICATION

A. Personal Information

1. Name:_____ 2. Social Security #: _____

3. Mailing Address: _____

_____ 4. E Mail Address: _____

5. Website (if applicable) _____

6. Phone #: _____ 7. Date of Birth (mm/dd/yy): _____

B. Practice Information

1. Primary Office Address: _____

_____

2. Phone #: _____ 3. Fax #: _____ 4. TaxID#:_____

5. Office Handicapped Accessible? Yes__ No __

6. Accessible by public transportation? Yes __ No__

7. Additional Office Address: _____

_____

7. Phone #: _____ 8. Fax #: _____

9. Is this office Handicap Accessible? Yes__ No__ 10. Public transportation accessible? Yes__ No__

11. Additional Office Address: _____

_____

12. Phone #: _____ 13. Fax #: _____

14. Is this office Handicap Accessible? Yes__ No__ 15. Public transportation accessible? Yes__ No__

16. Hours of operation (Please indicate office hours held/available each day; e.g. 9AM-6PM):

	Monday	Tuesday	Wednesday	Thursday	Friday	Sat.
Office 1						
Office 2						
Office 3						

FOR OFFICE USE ONLY- PROVIDER ID #:

17. Emergency/On-Call Information:

a. Do you have 24 hour on call availability? Yes__ No__

b. Describe how you are contacted in emergencies: _____

_____

c. List other clinicians used to provide on-call/ back-up coverage:

Name: _____ Licensure: _____ Phone #: _____

Name: _____ Licensure: _____ Phone #: _____

Name: _____ Licensure: _____ Phone #: _____

C. Education & Training

1. Undergraduate Degree: ___ Undergraduate School: _____ Dates: _____

2. Graduate Degree: ___ Graduate School: _____ Dates: _____

3. Describe Specialized Training/Experience:

a. Employee Assistance Programs- _____

_____

b. Community Mental Health- _____

_____

c. Organizational Development- _____

_____

d. Adult Training- _____

_____

e. Chemical Dependency- _____

_____

f. Consultation- _____

_____

g. Solution Focused Treatment- _____

_____

h. Inpatient and Alternative Care Experience- _____

_____

D. License, Certification & Professional Affiliation

1. Licensure

Title: _____ State: _____ License #: _____ Expiration Date:_____

2. Certification

Type: _____ Issued by: _____ Expiration Date: _____

3. List Professional Affiliations: _____

_____

E. Clinical Affiliations (*Hospitals, Substance Abuse Facilities, etc*.)

1. Facility Name and Address: _____

_____

2. Facility Name and Address: _____

_____

F. EAP Affiliations (*i.e., For whom do you, or have you, performed EAP services*?)

1. EAP Provider or Company: _____

Location: _____ Dates of service: _____

2. EAP Provider or Company: _____

Location: _____ Dates of service: _____

G. Accepted Insurances (Please list all insurance companies you are paneled with)

_____

_____

_____

_____

_____

_____

G. Clinical Experience

1. Years in Clinical Practice: _____

2. Areas of Special Interest and Expertise: _____

_____

_____

_____

_____

G. Professional Liability Information

1. Current Carrier: _____Policy #: _____

2. Amount of Coverage: $_____ Issue Date: _____ Renewal Date: _____

3. Check the correct answer below (if you answer yes to *any* of the following questions please enclose a detailed explanation with your completed application):

a. Is there anything that will adversely affect your ability to render services? Yes___No___

b. Has your professional liability insurance ever been denied, canceled, or non-renewed? Yes___No___

c. Have you ever had your professional license revoked, suspended, or limited? Yes___No___

d. Has any hospital ever censured, restricted, suspended, or revoked your privileges? Yes___No___

e. Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges? Yes___No___

f. Has your membership in any professional society or association ever been canceled, revoked, or censured? Yes___No___

g. Have you ever been named as a defendant in any criminal proceeding? Yes___No___

h. Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? Yes___No___

i. Have you ever been the subject of disciplinary proceedings by any professional association or organization? Yes___No___

j. Has any claim or suit for alleged malpractice been brought against you in the last 10 years, or are you aware of any circumstances that might lead to such a claim or suit against you? Yes___No___

I hereby declare that the information in this application is true

_____

Applicant Signature **Date**

H. Participation Statement

I understand that if any matter stated in this application is or becomes false, COMPREHENSIVE EAP will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true.

I authorize COMPREHENSIVE EAP to consult with hospital administrators, hospital staff members, malpractice carriers, and other persons to obtain and verify information concerning my professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to COMPREHENSIVE EAP. I release COMPREHENSIVE EAP and its employees and agents and all those whom COMPREHENSIVE EAP contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to COMPREHENSIVE EAP of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

_____ _____

Signature of Applicant Date

_____

Name of Applicant (Please Print)

RETURN COMPLETED APPLICATION BY MAIL, FAX OR EMAIL TO:

Comprehensive EAP
4 Mount Royal Ave, STE 310
Marlborough, MA 01752

FAX: 774-463-3455

jsagor@compeap.com