

## EAP Clinician Profile

|                             |  |
|-----------------------------|--|
| <b>Date of Application:</b> |  |
|-----------------------------|--|

### Contact Information

|                          |  |               |                       |             |  |
|--------------------------|--|---------------|-----------------------|-------------|--|
| <b>Business Name:</b>    |  |               |                       |             |  |
| <b>Clinical Address:</b> |  |               |                       |             |  |
| <b>City:</b>             |  | <b>State:</b> |                       | <b>Zip:</b> |  |
| <b>Last Name:</b>        |  |               | <b>First Name:</b>    |             |  |
| <b>Gender:</b>           |  |               | <b>Race(Optional)</b> |             |  |
| <b>Phone:</b>            |  |               | <b>Fax:</b>           |             |  |
| <b>Date of Birth:</b>    |  |               | <b>Cell:</b>          |             |  |

**Email:** \_\_\_\_\_

### Employee Assistance Counseling Experience

|  |                                     |                                    |
|--|-------------------------------------|------------------------------------|
| <b>I have at least ONE year experience providing Employee Assistance Counseling.</b>     | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| <b>Total Number of Years providing EAP Services</b>                                      |                                     |                                    |
| <b>If Yes, please list the names of the EAP Networks for which you provide Services.</b> |                                     |                                    |

### Practice Information:

|  |                                     |                                    |
|--|-------------------------------------|------------------------------------|
| <b>Assess/Refer children 5 yrs of age and up with their parents</b>  | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| <b>After providing an EAP Assessment, you may need to make a referral for a client, are you familiar with local community resources available for clients?</b> | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| <b>Do you provide Faith Based Counseling?</b>  | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| <b>Do you see clients in your home?</b>  | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| <b>Are you HIPAA compliant?</b>  | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |

### Do you provide a cultural or ethnic specialty in your practice? (Check all that apply)

|  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>African American</b>       | <input type="checkbox"/> <b>Asians</b>              | <input type="checkbox"/> <b>Gay/Lesbian</b>     |
| <input type="checkbox"/> <b>Hispanic</b>               | <input type="checkbox"/> <b>Holocaust Survivors</b> | <input type="checkbox"/> <b>Native American</b> |
| <input type="checkbox"/> <b>Vietnam Veterans</b>       | <input type="checkbox"/> <b>Veterans</b>            |   |
| <input type="checkbox"/> <b>Other (please specify)</b> |   |   |

|                            |  |
|----------------------------|--|
| <b>Foreign language(s)</b> |  |
|----------------------------|--|

**Please identify your areas of specialization: (check all that apply)**

|   |   |
|---|---|
| <input type="checkbox"/> Adjustment issues              | <input type="checkbox"/> Financial Issues           |
| <input type="checkbox"/> Alcohol Abuse                  | <input type="checkbox"/> Marital Issues             |
| <input type="checkbox"/> Anxiety Issues                 | <input type="checkbox"/> CISD/CISM                  |
| <input type="checkbox"/> Bereavement Issues             | <input type="checkbox"/> Parent/Child Issues        |
| <input type="checkbox"/> Childhood/ Adolescent Issues   | <input type="checkbox"/> Phase of Life Transition   |
| <input type="checkbox"/> Depression/Affective Disorders | <input type="checkbox"/> Physical Abuse             |
| <input type="checkbox"/> Domestic Abuse                 | <input type="checkbox"/> Relationship/Interpersonal |
| <input type="checkbox"/> Drug Abuse                     | <input type="checkbox"/> Separation/Divorce         |
| <input type="checkbox"/> Eating Disorder                | <input type="checkbox"/> Sexual Abuse               |
| <input type="checkbox"/> Educational/Learning Issues    | <input type="checkbox"/> Stress                     |
| <input type="checkbox"/> EMDR Training                  | <input type="checkbox"/> Work Place Issues          |
| <input type="checkbox"/> Family Issues                  | <input type="checkbox"/> Other:                     |

**To Receive Specialty Referrals Complete the Following:**

|  |                              |                             |
|--|------------------------------|-----------------------------|
| Do you have experience providing EAP Orientations/Trainings?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have experience providing Critical Incident Stress Debriefings?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have experience treating Alcohol & Substance Abuse?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you a Certified Employee Assistance Professional (CEAP)?<br>Please provide a copy of certification including expiration date | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Please indicate which insurance panels you are a member of:**

|                                       |                                       |   |                                       |  |
|---------------------------------------|---------------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> Aetna        | <input type="checkbox"/> First Health | <input type="checkbox"/> Kaiser Permanente      | <input type="checkbox"/> Pacific Care | <input type="checkbox"/> Value Options |
| <input type="checkbox"/> APHealthcare | <input type="checkbox"/> Guardian     | <input type="checkbox"/> Magellan               | <input type="checkbox"/> Prudential   | <input type="checkbox"/> Wausau        |
| <input type="checkbox"/> BCBS         | <input type="checkbox"/> Horizon      | <input type="checkbox"/> Managed Health Network | <input type="checkbox"/> Tri Care     | <input type="checkbox"/> WEA           |
| <input type="checkbox"/> Cigna        | <input type="checkbox"/> Humana       | <input type="checkbox"/> Oxford                 | <input type="checkbox"/> UBH          | <input type="checkbox"/> WPS           |

**Agreement**

I hereby certify that all of the responses and information provided pursuant to the above are complete, true, and correct, to the best of my knowledge.

|                   |  |
|-------------------|--|
| <b>Signature:</b> |  |
| <b>Title:</b>     |  |
| <b>Date:</b>      |  |