

**Metropolitan Family Services  
Employee Assistance Network**

**Clinical Affiliate Application**

Name: \_\_\_\_\_

Group Practice Name (if applicable): \_\_\_\_\_

*\*\*Please attach the credentials of the therapists in the practice who will be seeing EAP clients.*

Office Address (list all if there is more than one):

	<b>Mailing and Payment Address</b>	<b>Office Address #1</b>
<b>Street:</b>	_____	_____
<b>Suite/Room #:</b>	_____	_____
<b>City/State/Zip:</b>	_____	_____

	<b>Office Address #2</b>	<b>Office Address #3</b>
<b>Street:</b>	_____	_____
<b>Suite/Room #:</b>	_____	_____
<b>City/State/Zip:</b>	_____	_____

Payment of services to be made to: \_\_\_\_\_

Office Telephone:	_____	Intake Contact Person:	_____
24 Hour Telephone:	_____	Fax Number:	_____
Current Position/Title:	_____	Tax I.D. Number:	_____
Web-site:	_____	E-mail:	_____
		May we send clinical paperwork via email?	_____

**1. EDUCATION**

Highest Degree Earned: \_\_\_\_\_ Year: \_\_\_\_\_  
Program: \_\_\_\_\_ University: \_\_\_\_\_  
Alcohol/Drug Training: \_\_\_\_\_  
Number of years work experience (postgraduate): \_\_\_\_\_

**2. CERTIFICATION/LICENSURE**

*(Please attach copy of current license or certification)*

Type: \_\_\_\_\_ State: \_\_\_\_\_  
Year(s) Obtained: \_\_\_\_\_

Number of years providing counseling/therapy/evaluation: \_\_\_\_\_  
Number of years working in current geographical location: \_\_\_\_\_

3. Please specify populations in your practice:

- |                                   |                                      |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Children | <input type="checkbox"/> Adolescents |
| <input type="checkbox"/> Adults   | <input type="checkbox"/> Couples     |
| <input type="checkbox"/> Families |                                      |

4. Please specify primary areas of practice:

- |  |  |
|--|--|
| <input type="checkbox"/> Emotional/Psychological | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Marital/Relationship    | <input type="checkbox"/> Anger Management  |
| <input type="checkbox"/> Grief/Loss              | <input type="checkbox"/> Trauma            |
| <input type="checkbox"/> Divorce                 | <input type="checkbox"/> Career Counseling |
| <input type="checkbox"/> Job Stress              | <input type="checkbox"/> Substance Abuse   |
| <input type="checkbox"/> ADHD                    | <input type="checkbox"/> Other: _____      |
| <input type="checkbox"/> Compulsive Gambling     | _____                                      |

5. Please list primary therapeutic models:

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6. Do you have any other training (i.e. critical incident stress debriefing, SAP) that would be relevant?

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7. Please describe your experience providing EAP counseling:

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8. Please list workshops you could provide to employee groups:

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9. Do you speak a second language(s)?

- Spanish     French     Other: \_\_\_\_\_

10. Optional: Do you wish to have your race/ethnicity listed for response to a particular client's request for such a provider?  No  Yes

If yes, please specify: \_\_\_\_\_

11. Please list insurance carriers or managed care companies for which you participate as an in-network provider:

- |  |  |
|--|--|
| <input type="checkbox"/> PHCS            | <input type="checkbox"/> BC/BS PPO             |
| <input type="checkbox"/> Humana Provider | <input type="checkbox"/> United Healthcare/UBH |
| <input type="checkbox"/> Magellen        | <input type="checkbox"/> Others: _____         |
| <input type="checkbox"/> Cigna           | _____  |

12. Has your license/certification ever been suspended or revoked by any State licensure/certification board?

No  Yes—please explain:

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13. Have you ever been censured by a State Medical (or other professional) Society?

No  Yes—please explain:

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14. Liability Insurance: Please attach a copy of your current Professional Liability Insurance policy face sheet:

Name of carrier: \_\_\_\_\_

Coverage Limits per Occurrence: \_\_\_\_\_

Aggregate: \_\_\_\_\_

15. Reserve Affiliate Information (your coverage when you are on vacation, etc.)

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Degree: \_\_\_\_\_

I represent and warrant that the information provided herein is true, complete and correct.

I give Employee Assistance Network permission to verify this information that is usual and customary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach current resume or vitae to application along with:

- Copy of current license/certification
- Copy of current Professional Liability Insurance face sheet

**ATTENTION: In order to maintain active status in the EAN Affiliate Network, you must submit a copy of your current licensure and liability insurance on an ongoing basis.**

Return to: **Employee Assistance Network**  
**Attn: Provider Relations**  
**One North Dearborn, 10<sup>th</sup> Floor**  
**Chicago, IL 60602**  
**312-986-4249**  
**Fax#(312) 986-4187**