AFFLIATE EAP PROVIDER APPLICATION

Applicant's Name:

____

First Name Last Name M.I.

Organization: ____

Address:_______________________________ City:_________________ State: ______ Zip Code:_______

Cell phone: ______________________ Texting permitted? ☐ Yes ☐ No

Fax: (__)_________________ Work phone: (__)______________ Email: ___________________________

Is the Service Location:

☐Wheel-chair accessible	☐Parking available
☐Smoke-free	☐Clear signage for office space
☐Pet-free	☐Home office If home office: ☐Separate entrance ☐Separate space from private living space
☐Near public transportation	

Insurance Accepted: ☐ Yes ☐ No

☐CIGNA ☐CareFirst ☐EHP (Johns Hopkins) ☐UnitedHealth ☐Aetna ☐Other:
____

Service Information: What types of services are you willing to provide and have experience with?

☐ CISM (must have certification) ☐ Education seminars/presentations ☐ Management referrals

☐ EAP face-to-face counseling ☐ Web based trainings

Critical Incident Stress Responder: Best Contact number for CISM response (i.e. cell):
____

CISM Experience: ☐Bank robbery ☐Downsizing ☐Death/illness/incidents ☐Law enforcement

☐Terrorism/violence☐Natural disaster

Do you have a minimum of three years of general clinical experience? (This can include pre-graduate degree experience.)

☐Yes☐No

Availability of at least 20 hours per week in clinical practice and/or ability to offer an appointment to client within three business days of referral? ☐Yes ☐No

At least two years' experience providing EAP services on at least a half-time basis (and/or experience in assessing for chemical dependency conditions)? ☐ Yes ☐ No

What is your normal working schedule that you are available schedule that you are available for appointments:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
First Appointment Time							
Last Appointment Time							

EAP Face-to-Face Counseling:

Please list your four top areas of expertise—areas in which you have had education, training and experience.

1. Choose an item. ____

2. Choose an item. _ ____

3. Choose an item. __ ____

4. Choose an item. ____

Special Populations served (Select All the apply; i.e. Military, LGBT, first responders):

Choose an item.

Workplace Trainer: If you are applying to be a trainer, are you adept with using Microsoft PowerPoint (PPT) for training presentations and have expertise in providing group presentations? ☐ Yes ☐ No

Statement of Accuracy

I, the undersigned, hereby attest that all the information enclosed is complete, true and accurate, and fairly represents my mental health and wellness qualifications. Furthermore, I attest that all of the enclosed is truthful information. I authorize Freeform Wellness Advantage, LLC to consult with or request from any third party who may have information bearing on any subject addressed by this application, and to inspect or obtain records or documents of said third parties that may be relevant to this application. I also authorize any third parties to release information to Freeform Wellness Advantage, LLC and any authorized representative upon request. I hereby release Freeform Wellness Advantage, LLC and any representatives from any liability for any such reports or documents which hold information pertinent to this application. I hereby authorize and request any educational institutions or programs, professional review organizations, employers, peer review bodies, insurance carriers or others to disclose information and documentation to Freeform Wellness Advantage, LLC upon request, which will assist Freeform Wellness Advantage, LLC in its efforts to determine my professional and personal qualifications for the affiliate position for which I have applied. I agree that a photocopy or facsimile copy of this signed form is as valid as an original signed copy. ☐

Applicant's Signature: ________________________________ Date: ___________

Printed Name: _________________________________

Professional History Statement and Fair Credit Reporting Act

For quality assurance purposes, Freeform Wellness Advantage, LLC requires your response to the following questions. If you answer yes to any question, please include a written explanation and supporting documentation of the circumstances surrounding each item.

1.	Have any of your professional licenses/certifications ever been denied, revoked, suspended or limited?	☐YES ☐NO
2.	Is there any action pending to revoke, suspend or limit your professional licenses/certifications?	☐YES ☐NO
3.	Have you ever been denied professional liability insurance or has your insurance ever been canceled or denied renewal?	☐YES ☐NO
4.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those functions without a direct threat to the health and safety of others?	☐YES ☐NO
5.	Has there been any legal action pending related to your practice?	☐YES ☐NO

6.	Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county, state or national professional society; hospital, medical or clinical staff)?	☐YES ☐NO
7.	Are you currently engaged in the illegal use of drugs or controlled substances?	☐YES ☐NO
8.	Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude?	☐YES ☐NO
9.	Have you ever been named as a defendant in a criminal proceeding?	☐YES ☐NO
10.	Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of $25,000 or more?	☐YES ☐NO

Fair Credit Reporting Act: Disclosure and Authorization Statement

All providers (employees and independent contractors): Please read carefully before signing below. As part of its screening process, I understand that Freeform Wellness Advantage, LLC may obtain or have prepared a consumer/investigative consumer report concerning my prior employment, military record, education, credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, criminal background or mode of living. I understand that upon written request to Freeform Wellness Advantage, LLC, I will be informed whether an investigative consumer report was requested and given full information as to the nature and scope of such investigation. I understand that an investigative consumer report is a report in which information regarding my character, general reputation, personal characteristics, or mode of living, is obtained through personal interviews with neighbors, friends, or associates with whom I am acquainted. By signing below, I authorize Freeform Wellness Advantage, LLC to obtain a consumer/investigative consumer report on me as part of its pre-employment and pre-contracting background investigation process. If I am offered employment as either an employee or independent contractor by Freeform Wellness Advantage, LLC, I further authorize Freeform Wellness Advantage, LLC to obtain additional consumer/investigative consumer reports on me for employment and screening purposes at any time during my employment. ☐

Applicant's Signature: ________________________________ Date: ___________

Printed Name:_________________________________

Please upload this document with your provider information at FreeformWellness.com/providers-how-to-apply/ or forward it to:

Freeform Wellness Advantage, LLC

P. O. Box 30058
Washington, DC 20030

[E] info@freeformwellnessadvantage.com

[P] 202-827-9760 [F] 202-331-3759