ESI EMPLOYEE ASSISTANCE GROUP
TotalCare EAP
Public Safety EAP
Educators' EAP
Higher Ed EAP
HealthCare EAP

55 Chamberlain Street
Wellsville, NY 14895

SERVICE PROVIDER APPLICATION FORM

☐Mr. ☐Ms. ☐Mrs.

Name of Applicant_____ Date_____
Name Organization/PC_____ County_____
_____ Telephone_____
Practice Address_____ FAX No_____
_____ Tax ID No_____
Mailing Address _____ License No _____
_____ E-Mail_____
Professional Discipline_____
License/Certifications Held_____
_____
Educational Degree_____
Professional Organizations and Member status_____
_____
Type of Practice ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Individual/Sole Proprietor

Please Provide (3) Professional References

Name	Address	Telephone No

Are you enrolled in any insurance networks?_____ If so, list majors: _____
_____

MALPRACTICE PROFESSIONAL LIABILITY INSURANCE COVERAGE

Name of Carrier _____
Coverage Limits per Incident_____ Aggregate _____

Have you ever had a malpractice claim brought against you? _____If yes, please attach documentation of final resolution.

Has your professional license ever been limited, revoked or suspended? _____If yes, please give dates, reasons and attach documentation of final resolution.

Have you ever been disciplined by any professional association, organization, or professional society?___
If yes, attach documentation of final resolution.

Do you or your organization provide Employee Assistance Programs or other direct services to employers?
_____ If yes, please describe_____
_____

PROFESSIONAL CLINICAL CONCENTRATION

Method of Treatment
Individual Therapy _____ Family Therapy _____
Group Therapy_____ Brief Therapy_____
Services Provided
Please number up to 6 areas in which you have proficiency.
(No.1 being most proficient - No. 6 being least proficient.)

( ) Family/Marriage Counseling ( ) Children/Adolescents Age range _____
( ) Geriatrics ( ) Phobias
( ) Drug & Alcohol Evaluation ( ) Affective Disorders
( ) Drug & Alcohol Treatment ( ) Personality Disorders
( ) Christian Counseling ( ) DOT Assessment
( ) Eating Disorders ( ) Others _____

Days and hours you are willing to see clients?_____
Do you have experience in providing the following Workplace Services?

□ EAP Employee and Supervisory Training Presentation
□ Workplace Violence Prevention
□ Balancing Family Work/Life
□ Stress Management
□ Cultural Diversity
□ Sexual Harassment Sensitivity
□ Workplace Grief Bereavement Services
□ Critical Incident Stress Debriefing

Are you interested in providing on-site services indicated above?_____
Do you speak a foreign language?_____ If yes, Please specify, _____
_____
Can you use sign language? Yes_____ No _____
Is your office handicap accessible? Yes____ No_____
Please describe your office setting_____
_____

I authorize Employee Services to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to Employee Services for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of my knowledge and belief.

_____ _____
Applicant Signature Date

PLEASE ENCLOSE COPIES OF THE FOLLOWING DOCUMENTS FOR YOU AND YOUR CLINICAL STAFF: INSURANCE FACE SHEET, LICENSE/CERTIFICATION, DEGREE AND RESUME.