Quality Employee Assistance Programs.

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INDIVIDUAL
APPLICATION FOR APPROVED PROVIDER STATUS

Name:_____

Name of Practice:_____

Address: _____

City_____State_____Zip_____

Telephone_____ Fax_____

Social Security #: _____ Federal Tax I.D. #:_____

Email Address_____

If you have multiple office locations, please indicate other addresses and phone numbers:

_____

_____

_____

Emergency contact phone number: _____

Mailing address *(if different from primary address):*

_____

Names and credentials of those in group who would cover in your absence:

_____

_____

_____

DAYS/HOURS OF OPERATION:

- Weekdays *(Monday through Friday)*:_____
- Weekend *(Saturday and Sunday)*: _____

OPERATIONAL CAPABILITIES:

Is your telephone answered 24 hours a day? ☐Yes ☐No
Is your office accessible to the disabled? ☐Yes ☐No
Is your office served by public transportation? ☐Yes ☐No

What other cities/counties do you serve:_____

How many hours per week do you have that may be available for new referrals?_____

What is your usual waiting period for new clients?_____

Are you able and willing to make arrangements for emergency clients, e.g. need to be seen within 24 to 48 hours? ☐Yes ☐No

CREDENTIALS:

Professional degree: _____ Year attained: _____

Training institution: _____

LICENSES:

State:	Expiration date:
_____	_____
_____	_____
_____	_____

REGISTRATION *(if applicable):*

Drug Enforcement Admin. Reg. No.: _____ Expiration date: _____

Controlled Dangerous Substances Reg. No.: _____ _____

CERTIFICATION *(if applicable):*

Type:	Expiration date:
_____	_____
_____	_____

YEARS IN PRACTICE: _____

PROFESSIONAL LIABILITY INFORMATION:

Current carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Current coverage limits:

Aggregate: $ _____ Occurrence: $ _____

Date coverage first began: _____ Expiration date: _____

HISTORY:

Have any judgments ever been made against you in Professional Liability? ☐Yes ☐No

Are there any claims or cases presently filed against you? ☐Yes ☐No

Have you ever been censured by a professional board or association? ☐Yes ☐No

Has any facility or organization dismissed you from its staff? ☐Yes ☐No

Has any facility or organization revoked or suspended your general privileges? ☐Yes ☐No

Has any facility or organization initiated either type of above actions by formal notice to you or your representative? ☐Yes ☐No

Have you ever had criminal charges against you? ☐Yes ☐No

(Note: If you checked "yes" for any above item, attach a detailed description of the relevant facts, including the reason, the dates of action, and the final outcomes of these actions.)

PRACTICE INFORMATION:

Check client population you serve:

☐Senior Citizens ☐Family ☐Adolescents ☐Children

☐Adults ☐Groups ☐Couples

List any languages other that English that you speak:_____

Check the services you provide:

Evaluation and Referral ☐Mental Health ☐Substance Abuse

Specialized and Traditional Practice ☐Mental Health ☐Outpatient-General Practice
☐Outpatient-Specialized Practice ☐Substance Abuse

Brief Treatment ☐Mental Health ☐Substance Abuse

Crisis Evaluation/Intervention ☐Mental Health ☐Substance Abuse

Employee Assistance ☐Mental Health ☐Substance Abuse

Utilization Review ☐Inpatient ☐Outpatient

THERAPUETIC APPROACHES:

☐Behavioral ☐CBT ☐DBT ☐EMDR

☐Gestalt ☐Narrative ☐Psychodynamic

☐Motivational Interviewing ☐Rational Emotive ☐Solution Focused

☐Strategic Family Therapy ☐Structural Family Therapy ☐Transactional Analysis

☐Transgenerational Family Therapy ☐Other

SPECIALTY AREAS:

☐ADD/ADHD ☐Anger Management ☐Anxiety Disorder

☐Chemical Addictions ☐Child Abuse ☐Chronic Illness

☐Couples ☐CISD ☐Domestic Violence Perpetrators

☐Domestic Violence Survivors ☐Eating Disorders ☐Families

☐Gay/Lesbian Issues ☐Grief/Death ☐Learning Disorders

☐Mentally Ill ☐Mood Disorder ☐ODD ☐Personality Disorder

☐Postpartum Depression ☐PTSD ☐Religious ☐Sexual Assault Survivors

☐Sexual Compulsivity ☐Stress Management ☐Other

What physician services do you provide?

INPATIENT:

_____

_____

OUTPATIENT:

☐Medication evaluation ☐Medication review ☐Psychotherapy?

List hospitals where you have admitting privileges: _____

_____

RETURN THE FOLLOWING WITH THIS APPLICATION:

- ⇒ Copy of your current State License
- ⇒ Copy of your current Malpractice Insurance
- ⇒ Your Curriculum Vitae
- ⇒ Copy of any other applicable certification or registration
- ⇒ Board Certification (if applicable)

I hereby submit this application to be a provider in the Wayne Corporation network and understand that my application will be reviewed based on the information I have provided here. I understand that any misstatements in or omissions from this application could result in denial or subsequent termination of participation.

I also release from liability all individuals and organizations who provide information in good faith to Wayne Corporation concerning my qualifications as represented here.

_____ _____

Signature **Date**