PRACTICE INFORMATION SHEET

Date______________________________

Counselor's Name____ **Credentials**______________________

Organization Name:____

Or

Practice/Group Name (dba)__________________________________ **National Provider #**__________________

Mailing Address:____

Practice Address:____

City:____ State:__________________ Zip:_________________

Phone Listings:

Office:________________________ Pager:________________________ Cell:___________________________

Fax:__________________________ Emergencies:_________________ E-Mail:__________________________

Do you specialize in any of the following areas?

Abuse Issues	Career Counseling	Family of Origin Issues	Performance Problems
ACOA	Children's Issues	Gambling	Play Therapy
ADD/ADHD	Christian Counseling	Grief and Loss	Psych Evaluation
Adolescent Issues	Co-dependency	Group Therapy	Relationship Issues
Alcohol/Drug Issues	Depression/Mood Disorders	Health Problems	School Problems
Alternative Lifestyles	Divorce/Mediation	HIV/AIDS	Sex Therapy
Anger Management	Domestic Violence	Impaired Professionals	Sexual Abuse
Anxiety/Disorders	Eating Disorders	Internet Addiction	Stress Management
Behavioral Problems	Elder Issues	Men's Issues	Trauma/PTSD
Blended Families	Ethnicity/Minority Issues	Parenting Issues	Women's Issues

EAP Assessment EAP Childcare EAP Eldercare EAP Financial EAP Legal

Of the above list, what would you say are your three (3) main areas of interest?

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Do you work with clients who have been referred to EAP due to job performance issues? Yes__ No__

Is your practice: Adult Only___ Children Only___ Both ___ Do you work with perpetrators? Yes__ No__

Do you provide group therapy? If so in what area(s)____

Do you have an interest in becoming a Network Trainer for First Sun EAP? Yes____ No____

Do you have any of the following special abilities/certifications?

- Alcohol/Drug Assessment Yes____ No____ (Please attach copy of certificate)
- Critical Incident Debriefing Yes____ No____ (Please attach copy of certificate)
- Speak a second language Yes____ No____ Please list____________________________ Fluent Yes____ No____
- Work with children Yes____ No____ Please list age ranges__________________________
- Certified Employee Assistance Professional (CEAP) Yes____ No____ (Please attach copy of certificate)

Do you provide on-site Critical Incident Response? Yes____ No____

Are you affiliated with a national critical incident response group? Yes____ No____ If so, which group

____

The following information assists our assessment staff in completing the referral process by matching clients with resources based on client request/expectation and presenting problem:

Your Gender:________________________ Your Age: ________ Your Ethnicity:_________________________________

Is your office handicapped accessible?: Yes____ No____

Days/Hours available to see clients:____

Insurance Panels (please list panels you are on):____

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