



Please Check Application Type:

Provider

Affiliate

Note: To be included in our directory you or your company must be a reputable Health Provider, EAP or work-life provider that is properly licensed, insured and operating at a valid business address. If accepted as a provider or affiliate, you may be subject to on-site inspections. We do not endorse providers or affiliates and we reserve the right to terminate any provider or affiliate from our network. Please complete the following:

Individual Service Provider - Company Name(s): _____

Note: If there are more than two addresses, please attach additional information.

Address(1): Wheelchair access? Y or N

Address(2): Wheelchair access? Y or N

Telephone: _____

Fax: _____

Telephone: _____

Fax: _____

Web site and/or E-mail address: _____

Year company was founded: _____ **Year services began:** _____

Parent company (if applicable): _____

1. EAP-Work/Life Services - Please indicate which of the following you provide:

- Chemical Dependency Other Addictions Preventing Workplace Violence
- SAP Substance Abuse Professional Assessment Return to Work Assessment
- Critical Incident Stress Debriefing Supervisory Orientations
- Employee EAP Orientations Smoking Cessation
- Dependent care evaluations Child Care Elder Care Long-term illness
- Temporary illness/emergency care
- Parenting seminars Child Development Surviving Your Teens Adolescence
- Special needs services (learning disabled, gifted & talented, physical disability accommodations)
- Anger Management Balancing Family and Work Stress Reduction
- Achieving Peak Performance Debt Reduction/Budgeting Other Specialty(ies):

2. Program Services - Please indicate which of the following you provide:

- Needs assessment
- Employee interviews
- Employee questionnaires
- Task force formation
- Cost/benefit analysis
- Consulting on employer/employee financing options (such as: vouchers, preferential enrollment/discounts, dependent care assistance program accounts, flex benefit plans)
- Regulatory advice
- Focus groups
- Feasibility studies
- Start-up and operation budget preparation
- Community resource development

3. Communications & Quality Assurance - Please indicate which of the following you provide:

- Management reporting
- Management training
- Vendor references
- Customized employee communications (newsletters, online data, videos, booklets, etc.)
- On-site visits
- Employee satisfaction follow-ups
- Management debriefing of problems

4. List Name(s) & Professional License(s), Certification(s) and State(s) of License and/or Certificate:

_____	_____
_____	_____
_____	_____
_____	_____

5. Liability Insurance and Dates of Coverage:

_____	_____
_____	_____

Have you ever been accused of professional misconduct or refused liability insurance coverage? If so, please provide details. _____

★ Please enclose copies of your educational degrees, licenses, certificates and liability coverage.

This does not constitute an agreement, but merely a request to be considered as a provider or as an affiliate within our network.
Thank you for your interest in joining our team.



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