Aurora Employer Solutions Employee Assistance Program



Affiliate Application- Individual

Name:					Credentials:					
	Last	First			MI					
Social	Security #:		DOB:			_	Sex:	Male	Female	
Clinic	Name:									
Addre	ess:					City, St	ate, Zip:_			
Phone	2:	Fax:				_	Email:_			
Experi	ience:									
	ental Health	☐ CEAP] Trauma/	Grief		☐ Othe	r		
	Number of years providing counseling/ the			_			_			
	Number of years providing EAP Assessmen Are you qualified to provide SAP (substanc		essional)	_	l Yes	□No	_			
a	ssessments for the Department of Transpo	ortation?	233.3.1.4.7	_						
	Can you provide EAP orientations/ training Can you provide CISD/ crisis interventions?				l Yes l Yes	□ No □ No				
	anguages other than English?			<u></u>	1 162					<u></u>
You N	1UST include copies of the following:									
	tate Certification(s)/License(s), Resumé A	ND Malpract	ice Insurar	nce and ac	lditiona	l supporti	ng mater	ial, if nee	ded.	
-	ou or have you been subject to the followi	ng <i>(If you an</i>		any of th				a comple		
	Professional liability insurance cancellation		five (5) yea	rs?					☐ Yes	□ No
2. S	suspension as a Medicare or Medicaid Pro-	vider?							☐ Yes	□ No
3. S	tate licensing investigations or actions?								☐ Yes	□ No
	Any certifications ever revoked, limited, or	·							☐ Yes	□ No
5. C	Clinical privileges ever been suspended, lin	nited, or with	ndrawn for	cause?					☐ Yes	□ No
6. C	Conviction of a felony, or moral or ethical o	rime?							☐ Yes	□ No
	Any addictions, chronic illness, or physical/psychological limitations that would impair your ability to practice your specialty?							practice	☐ Yes	□ No
8. [Dismissed or received disciplinary action fo	r reasons of	sexual mis	conduct?					☐ Yes	□ No
	lave you ever voluntarily given up privileg greed to restrict your practice in lieu of or	_			censure	e to practi	ce therap	y, or	☐ Yes	□ No
	n that all information contained in this applicati yee Assistance Professionals Association ("EAPA	-								that I adhere to the
	by give Aurora Employee Assistance Program tholation found or any case opened against me.	e right to seek	and obtain	a report fr	om any	licensing or	certificati	on commit	tee to whic	h I belong pertaining t
body, į	give permission to Aurora Employee Assistance professional association, agency or court, and A isors, or superiors as shall be deemed necessar	urora Employ		•						_
	ave received and read the Affiliate Mand I agree that my activities as an Affiliate		_					-	es the Aff	iliate must comply
Signat	cure:						Date:			
Sand	completed applications to: EAR Network				u oa nd	Ctroot, M/	······································	W/I E222	2 or fay to	111 760 E110