MATRIX

INTEGRATED PSYCHOLOGICAL SERVICES
EMPLOYEE ASSISTANCE PROGRAMS INC.

EAP Provider Application

Name_____Degree_____
First Middle Last

Tax ID#_____SS#_____Date of Active Practice_____

Professional licenses _____State_____#_____Exp.Date_____

_____State_____#_____Exp.Date_____

Education training:

Highest Degree Attained_____Year Graduated_____

Area of Specialization_____University Attended_____

Dept._____

Internship_____Year_____ APA Approved___Yes___No

Office Address:

	Primary Location	Secondary Location
Facility Name	_____	_____
Street Address	_____	_____
City, State, ZIP	_____	_____
10-Digit Phone	_____	_____
Home Phone	_____	_____
Office Fax #	_____	_____
E-mail Address	_____	_____

Mailing Address (if different from locations) _____

Type of Practice:
Check all that apply:

__Academic Performance
__Anxiety
__Career Issues
__Depression
__Divorce
__Gay/Lesbian Issues
__Grief/Loss
__Infertility
__Men's Issues
__Parenting Skills
__Phobias
__Sexual Abuse/Incest
__Sexual Perpetrators
__Women's Issues
__ACOA
__AIDS/HIV
__ADHD/ADD
__Child Abuse
__Family Therapy
__Gender Identity
__Learning Disabilities
__Mood Disorders
__OCD
__Personality Disorders
__PTSD
__Sexual Disorders /dysfunction
__Stress Management
__Work Issues
__Alcohol/Substance Abuse
__Anger Management
__Bipolar Disorders
__Chronic/Terminal Illness
__Geriatric Issues
__Marital/Couples
__Multi-Cultural Issues
__Panic Attacks
__Physical Abuse
__Postpartum Depression
__Rape Issues
__Sexual Orientation
__Testing
__Eating Disorders

Please describe other types of clients seen that are not on the above checklist:_____

_____

_____

Age of Clients Seen:_____

Is your business wheelchair accessible? _____yes_____no

Do you identify yourself as a culturally diverse practitioner? _____yes_____no
If Yes, please specify_____

Areas or Types of Clients you prefer **NOT** to see:

_____

What arrangements do you and your office have for 24-Hour, 7-day coverage for emergencies? (i.e.—if a current client needs to get in touch with you or another provider during an emergency, do you make sure that they know the procedure? What is that procedure?)

_____

_____

What is your theoretical orientation?

_____

_____

Please list any additional languages in which you have fluency:_____

Medical Malpractice/Liability

****Please attach a copy of your malpractice insurance certificate**

_____ _____/_____ _____
Carrier Malpractice amount per Occurrence /per year Exp. Date

1. Have you ever been a party to charges of malpractice or are you presently involved in any such litigation?
___Yes__No

2. Has your license to practice ever been denied, restricted, limited, suspended, or revoked, or have you been reprimanded by a licensing agency?
____Yes__No

3. Have any complaints been filed against you?
___Yes___No

4. Are you now being treated for alcoholism or drug addiction?
___Yes___No

5. Have you ever been charged with a felony or misdemeanor, other than a simple traffic violation?
___Yes___No

6. Have you ever been or are you now under investigation by a regulatory agency (e.g. medicare, state health department)?
___Yes___No

****IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE ATTACH EXPLANATION.**

Membership/Professional Affiliations:

1) _____

2) _____

3) _____

Other EAP/Managed care networks in which you participate:

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Office Hours

Are you willing to see patients on an emergency basis within an hour notice?
___Yes___No

List the hours you see patients:

Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____
Saturday_____Sunday_____

Other therapists in your practice who would be available to see EAP clients:

_____

To whom do you refer cases requiring psychiatric attention?

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
(Area Code) Tel. #	(Area Code) Tel. #

To whom do you refer cases of substance abuse or chemical dependency?

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
(Area Code) Tel. #	(Area Code) Tel. #

From time to time Matrix is asked to send a psychologist to an employer's site for counseling regarding issues such as difficult terminations, death of a co-worker, etc. Would you like to be contacted for such referrals? ___Yes___No

If yes, please briefly describe your experience in this area.

_____

_____

_____

I hereby certify that all statements made in the above application are true.

Signature:_____Date:_____

Print Name:_____

Witness Signature:_____Date:_____

Print Name:_____

****Please attach copies of your Curriculum Vitae,
Certificate of Insurance, Professional License and Doctorate Diploma****

**Return To:
Matrix Psychological Services
2 Easton Oval, Suite 450
Columbus, OH 43219
614/475-9500 800/886-1171 FAX 614/475-9821**

www.matrixpsych.com

Below is a checklist for required items. Please be sure that all of the required items are enclosed before mailing or faxing in. Thank you.

- ☐ Completed Application.
- ☐ Explanation for any malpractice question answered yes.
- ☐ Witness signature on this page.
- ☐ Curriculum Vitae.
- ☐ Certificate of Insurance.
- ☐ Doctoral Diploma.
- ☐ Copy of Current License.