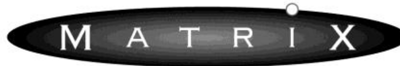

INTEGRATED PSYCHOLOGICAL SERVICES
EMPLOYEE ASSISTANCE PROGRAMS INC.

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 ____________________________ ________________________________

Office Fax # ______________________________ ________________________________

E-mail Address____________________________ ________________________________

Mailing Address (if different from locations) ____

Type of Practice:
Check all that apply:

__Academic Performance
__ACOA
__ADHD/ADD
__Alcohol/Substance Abuse
__Anger Management
__Anxiety
__Bipolar Disorders
__Career Issues
__Child Abuse
__Chronic/Terminal Illness
__Depression
__Divorce
__Eating Disorders
__Family Therapy
__Gender Identity
__Geriatric Issues
__Grief/Loss
__Impulse Control Disorders
__Learning Disabilities
__Marital/Couples
__Men's Issues
__Mood Disorders
__Multi-Cultural Issues
__Neurodevelopmental issues
__OCD
__Panic Attacks
__Parenting Skills
__Personality Disorders
__Phobias
__Physical Abuse
__Postpartum Depression
__PTSD
__Self Injury
__Sexual Abuse/Incest
__Sexual Disorders
__Sexual Orientation
__Sexual Perpetrators
__Sleep/Wake Issues
__Stress Management
__Trauma
__Women's Issues
__Work Issues

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

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? Do you have an answering service or answering machine that is checked on a regular basis? Or a 24/7 cell phone or pager?)

____

____

____

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 or are you currently a party to charges of malpractice, or are you aware of any incident or existing circumstances that might reasonably lead to such a claim?
___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

7. Have you ever been accused of sexual misconduct or any professional impropriety?
___Yes___No

8. Do you know of any reason why you or any of your employees cannot comply with the legal, ethical, or professional standards set by law, regulation, a peer review committee, or an applicable code of ethics in any jurisdiction where you provide services?
___Yes___No

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

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.
- ☐ Current License
- ☐ Curriculum Vitae.
- ☐ Certificate of Insurance.
- ☐ Diploma.