ESI GROUP
TotalCare EAP
Public Safety EAP
Educators' EAP
Higher Ed EAP
HealthCare EAP
Union AP

SERVICE PROVIDER APPLICATION FORM

55 Chamberlain Street Wellsville, NY 14895

☐Dr.☐Mr.☐Ms.☐Mrs.	Date
Name Organization/PC	Telephone
Practice Address	FAX No.
	E-Mail
Mailing Address	☐CAQH ☐NPI No.
License/Certifications Held	License No.

Type of Practice ☐Corporation ☐Partnership ☐Sole Proprietorship
Office setting ☐Group Practice ☐Private Practice ☐Home Office ☐ Other_____

Major Insurance Network Enrollment

Malpractice Professional Liability Insurance Coverage

Carrier	Coverage Limits per Incident	Aggregate

Have you ever had a malpractice claim brought against you? ☐ No ☐ Yes
Has your professional license ever been limited, revoked or suspended? ☐ No ☐ Yes
Have you ever been disciplined by any professional association, organization, or professional society? ☐ No ☐ Yes
(If yes to any of the three previous questions, please attach documentation of final resolution.)

Professional Clinical Concentration
☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy ☐ Brief Therapy

Areas of Specialization
☐Family/Marriage Counseling ☐Geriatrics ☐Drug/Alcohol Evaluation ☐Phobias
☐LGBTQ ☐Trauma/PTSD ☐Public Safety
☐Christian Counseling ☐Eating Disorders ☐Drug/Alcohol Treatment ☐Personality Disorders
☐Children/Adolescents:_____ ☐DOT Assessment ☐Affective Disorders ☐Other:_____

Days and Hours of availability: _____

Workplace Services
☐Critical Incident Stress Debriefing ☐Workplace Grief/Bereavement ☐ Employee/Supervisory Trainings

Are you interested in providing on-site services indicated above? ☐ No ☐ Yes

Do you speak a foreign language? ☐ No ☐ Yes, please specify_____
Can you use sign language? ☐ No ☐ Yes
Is your office handicap accessible? ☐ No ☐ Yes
Do you or your organization provide direct services to employers? ☐ No ☐ Yes, please specify_____

I authorize Employee Services to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to Employee Services for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of knowledge and belief.

_____ _____
Applicant Signature Date

PLEASE ENCLOSE COPIES OF THE FOLLOWING DOCUMENTS FOR YOU AND YOUR CLINICAL STAFF: INSURANCE FACE SHEET, LICENSE/CERTIFICATION, W-9, AND RESUME.