INDIVIDUAL PROVIDER APPLICATION

GENERAL INFORMATION

Last Name **First Name** **Middle** **Degree/License**

Social Security Number **Tax Identification**

Date of Birth: _____ **Sex: □ Male □ Female**

Office Location(s) (attach as needed):

Practice Name_____ _____ _____

Street **Suite**

City **State** **County** **Zip**

Telephone No:_____ Fax: _____

Alternate Phone: _____

Email: _____

Preference for receiving referrals: □ Email □ Fax □ Phone

Website:_____ □N/A

Mailing or Billing Address (if different):

Street **Suite**

City **State** **County** **Zip**

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Handicap Accessible? □ Yes □ No

List languages fluent in other than English: _____

LIABILITY/MALPRACTICE COVERAGE INFORMATION: Please provide copy Liability Insurance Certification

Present Carrier: _____

Date of most recent Child Abuse Clearance? _____

SPECIALTY AREAS
(Please check off all areas in which you have clinical competence)

□ Abuse/Neglect	**□ Addictive Behaviors**	**□ Anxiety Disorders**
□ ADHD	**□ Biofeedback**	**□ Bipolar Disorder**
□ Career Counseling	**□ Chronic Pain**	**□ Co-Occurring Disorders**
□ Depression	**□ Eating Disorders**	**□ Geriatric Issues**
□ Grief/Bereavement	**□ LBGTQ Issues**	**□ Marital/Family**
□ Men's Issues	**□ Phase of Life Issues**	**□ Play Therapy**
□ Psychosis	**□ Substance Use**	**□ Trauma**
□ Workplace Issue	**□Other (Please specify): _____**	

Are you able to offer a routine appointment within 3 business days? □ Y □ N
Do you provide crisis intervention services/ debriefings?: □ Y □ N
Do you have evening hours □ Y □ N

PRACTICE POPULATIONS

____ Children (5 -12)	**____ Adults (18-54)**
____ Adolescents (13-17)	**____ Geriatric (55+)**

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Please submit copies of the following with this application:

Current State License(s)
Certifications (CADC, CAADC, DEA, RPT etc.)
Proof of malpractice liability coverage with specified amount
(e.g. cover sheet)
Resume, CV or Bio

I certify that the information provided in this application is correct to the best of my knowledge. I understand that any information contained in this application which subsequently is found to be false could result in denial of my application or termination from network participation.

Signature **Date**