EAP Affiliate Application

A. Personal Information

1. Name:______________________________ 2. Social Security #: ______________
3. Mailing Address: ______________________________
4. E Mail Address: ______________________________
5. Website (if applicable) ______________________________
6. Phone #: ______________________________ 7. Date of Birth (mm/dd/yy): ______________

B. Practice Information

1. Primary Office Address: ______________________________
2. Phone #: _ ______________________ 3. ID#: ______________________
4. Office Handicapped Accessible? Yes__ No __ 5. Public Transportation Accessible? Yes __ No__
6. Additional Office Address: ______________________________
7. Hours of operation (Please indicate office hours held/available each day; e.g. 9AM-6PM):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Office 1							
Office 2							
Office 3							

FOR OFFICE USE ONLY- PROVIDER ID #:

Emergency/On-Call Information:

a. Do you have 24 hour on call availability? Yes__ No__

b. Describe how you are contacted in emergencies: ______________________________

____

c. List other clinicians used to provide on-call/ back-up coverage:

Name: ____________________ Licensure: ____________________ Phone #: ____________

Name: ____________________ Licensure: ____________________ Phone #: ____________

Name: ____________________ Licensure: ____________________ Phone #: ____________

C. Education & Training

1. Undergraduate Degree: ___ Undergraduate School: ________________________ Dates: _____________

2. Graduate Degree: ___ Graduate School: ______________________________ Dates: _________________

3. Describe Specialized Training/Experience:

a. Employee Assistance Programs

____

b. Organizational Development

____

c. Adult Training-

____

d. Chemical Dependency

____

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e. HR/Supervisory Consultation-

f. Solution Focused Treatment-

D. License, Certification & Professional Affiliation

1. Licensure

Title: State: License #: Expiration Date:

2. Certification

Type: Issued by: Expiration Date:

3. List Professional Affiliations:

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E.EAP Affiliations (i.e., to whom do you, or have you, performed EAP services?)

1. EAP Provider or Company:

Location: Dates of service:

2. EAP Provider or Company:

Location: Dates of service:

F. Accepted Insurances

Please list all insurance companies you are paneled with

____

____

____

____

____

H. Experience

1. Years in Clinical Practice: ____

2. Please check all that apply to your practice:

_____ Ages 0-5
_____ Ages 6-12
_____ Ages 13-18
_____ Adults
_____ Geriatrics

_____Individuals
_____Couples
_____Families
_____Parent Guidance

3. Areas of Special Interest and Expertise: ____

____

____

____

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I. Professional Liability Information

Check the correct answer below

(if you answer yes to any of the following questions please enclose a detailed explanation with your completed application):

1. Is there anything that will adversely affect your ability to render services? Yes___No___
2. Has your professional liability insurance ever been denied, canceled, or non-renewed? Yes___No___
3. Have you ever had your professional license revoked, suspended, or limited? Yes___No___
4. Has any hospital ever censured, restricted, suspended, or revoked your privileges? Yes___No___
5. Have you ever surrendered your clinical privileges upon threat of censure, Restriction, suspension or revocation of such privileges? Yes___No___
6. Has your membership in any professional society or association ever been Canceled, revoked, or censured? Yes___No___

7. Have you ever been named as a defendant in any criminal proceeding? Yes___No___
8. Have you ever been convicted of a felony or involved in charges relating to Moral or ethical turpitude? Yes___No___
9. Have you ever been the subject of disciplinary proceedings by any professional association or organization? Yes___No___
10. Has any claim or suit for alleged malpractice been brought against you in the last 10 years, or are you aware of any circumstances that might lead to such a claim or suit against you?

I hereby declare that the information in this application is true

Applicant Signature ______________________ Date ______________________

J. Participation Statement

I understand that if any matter stated in this application is or becomes false, **SUPREME HEALTHCARE MANAGEMENT SERVICES** will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true.

I authorize **SUPREME HEALTHCARE MANAGEMENT SERVICES** to consult with hospital administrators, hospital staff members, malpractice carriers, and other persons to obtain and verify information concerning my professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to **SUPREME HEALTHCARE MANAGEMENT SERVICES**. I release **SUPREME HEALTHCARE MANAGEMENT SERVICES** and its employees and agents and all those whom **SUPREME HEALTHCARE MANAGEMENT SERVICES** contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to **SUPREME HEALTHCARE MANAGEMENT SERVICES** of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

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___________________________________ ______________________

Signature of Applicant Date

____

Name of Applicant (Please Print)

RETURN COMPLETED APPLICATION BY MAIL OR EMAIL TO:

Supreme Healthcare Management Services
212 Suite Sir Arku Korsah Road
Roman Ridge, Accra-Ghana
OR EMAIL TO: info@supreme-healthcare.com

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