



Aurora Health Care®
Aurora Employee Assistance Program

Affiliate Application- Individual

Name: _____ Credentials: _____
 Last First MI

Social Security #: _____ DOB: _____ Sex: Male Female

Clinic Name: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

Experience:

Mental Health AODA CEAP Trauma/ Grief Other _____

1. Number of years providing counseling/ therapy? _____
2. Number of years providing EAP Assessments? _____
3. Are you qualified to provide SAP (substance abuse professional) assessments for the Department of Transportation? Yes No
4. Can you provide EAP orientations/ trainings? Yes No
5. Can you provide CISD/ crisis interventions? Yes No
6. Languages other than English? _____

You MUST include copies of the following:

- State Certification(s)/License(s), Resumé AND Malpractice Insurance and additional supporting material, if needed.

Statement of Professional Ethics and Conduct

Are you or have you been subject to the following (If you answer yes to any of the following, please attach a complete written explanation.):

1. Professional liability insurance cancellation in the past five (5) years? Yes No
2. Suspension as a Medicare or Medicaid Provider? Yes No
3. State licensing investigations or actions? Yes No
4. Any certifications ever revoked, limited, or suspended? Yes No
5. Clinical privileges ever been suspended, limited, or withdrawn for cause? Yes No
6. Conviction of a felony, or moral or ethical crime? Yes No
7. Any addictions, chronic illness, or physical/psychological limitations that would impair your ability to practice your specialty? Yes No
8. Dismissed or received disciplinary action for reasons of sexual misconduct? Yes No
9. Have you ever voluntarily given up privileges, registration, certification or licensure to practice therapy, or agreed to restrict your practice in lieu of or to avoid formal action? Yes No

I affirm that all information contained in this application is complete and accurate to the best of my knowledge. My signature below indicates that I adhere to the Employee Assistance Professionals Association ("EAPA") code of ethics and EAPA standards regarding confidentiality and record keeping.

I hereby give Aurora Employee Assistance Program the right to seek and obtain a report from any licensing or certification committee to which I belong pertaining to any violation found or any case opened against me.

I also give permission to Aurora Employee Assistance Program to request appropriate information regarding the action(s) named above from the relevant regulatory body, professional association, agency or court, and Aurora Employee Assistance Program to communicate with all people listed as my endorsers, teachers, supervisors, or superiors as shall be deemed necessary.

I have received and read the Affiliate Manual (www.aurora.org/eapaffiliates) and understand the procedures the Affiliate must comply with. I agree that my activities as an Affiliate shall be bound by, and I shall comply with, the Affiliate Manual.

Signature: _____ Date: _____

Send completed applications to: EAP Network Coordinator, Aurora EAP, 2640 N. 6th St.; Sheboygan, WI 53083 or fax to 920-451-5057.