FAR WEST FAMILY SERVICES

Employee Assistance Program

AFFILIATE PROVIDER APPLICATION FORM

PROVIDER NAME: ______________________________ TODAY'S DATE: ______________

CREDENTIAL: ______________________________ DATE LICENSED: ______________

DEGREE GRANTING UNIVERSITY/INSTITUTION: ______________________________ DATE: ______________

PROFESSIONAL MEMBERSHIPS: ______________________________

OFFICE ADDRESS: ______________________________ CITY ______________ ZIP ______________

OFFICE PHONE ______________________________ CELL PHONE ______________

EMAIL ADDRESS ______________________________ WEBSITE: ______________

AREAS OF EXPERTISE:

- ❑ COUPLES COUNSELING
- ❑ FAMILY THERAPY
- ❑ CHILDREN (UNDER 10)
- ❑ ADOLESCENTS
- ❑ LIFE COACHING
- ❑ PARENTING
- ❑ ADD/ADHD
- ❑ EATING DISORDERS
- ❑ GRIEF/LOSS
- ❑ TRAUMA/PTSD
- ❑ EMDR
- ❑ ELDERCARE
- ❑ DRUG/ALCOHOL
- ❑ OTHER ADDICTIONS
- ❑ CBT/DBT

OTHER ______________________________

INSURANCE PANELS YOU ARE ON: ______________________________

LANGUAGES OTHER THAN ENGLISH YOU SPEAK FLUENTLY IN THERAPY ______________________________

CLINIC DAYS AND TIMES: ______________________________

____

❑ PLEASE ATTACH A RESUME AND INTRODUCTORY LETTER.

MAIL OR FAX COMPLETED FORM AND RESUME TO:

FAR WEST FAMILY SERVICES

PO BOX 3271

EDMONDS, WA 98020

EMAIL: DIANA.NIELSEN@COMCAST.NET

425-582-8748 FAX

206.682.8149 PHONE

THANK YOU.