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: _____

PROVIDE TELEHEALTH? ❑ YES ❑ NO

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.