Clinical Profile

Name of Applicant: ____________________________________________________________

EAP Experience

1. Please list your training in brief and/or solution focused counseling (include EAP training):
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. Please list your experience in conducting brief and/or solution focused counseling (include EAP experience):
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. Please list any trainings or mediations you have provided:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
Name of Applicant: ________________________________

NOTE: If "YES" is checked, please explain fully on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudication, original complaint and final disposition). Your signed statement regarding the alleged incident will suffice for pending cases.

1. **Health Status:** Do you currently have any physical, mental, or emotional condition, which may impair your ability to render professional services, which are the subject of this application?
   a. Do you currently use illegal drugs or abuse drugs or alcohol? □ Yes □ No

2. **Insurance Coverage:** Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application? □ Yes □ No

3. **License:** Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?
   a. Have you ever voluntarily surrendered your license? □ Yes □ No
   b. Are formal charges pending against you at this time? ................................. □ Yes □ No

4. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured? □ Yes □ No

5. **Criminal Offenses:** Have you ever been convicted of a felony or involved in charges relating to unlawfulness? □ Yes □ No

6. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county;, state or national professional society hospital medical or clinical staff)? □ Yes □ No

7. **Malpractice Action:** Has any malpractice action against you been brought or settled in the last 5 years or has there been any unfavorable judgments(s) against you in a malpractice action?
   a. To your knowledge, is any malpractice action against you currently pending? □ Yes □ No

8. **Medicare/Medicaid:** Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid? □ Yes □ No

I hereby attest that the information above is true and correct.

____________________________________________________________      ____________________
Signature                                                  Date

In order for your application to be processed, please provide a copy of the following items:

___Application                                            ___Proof of Malpractice Insurance
___Clinical Profile and Attestation                      ___CEAP (if applicable)
___Specialty Checklist                                    ___Substance Abuse Certification SAP
___Affiliate Agreement (signed & dated)                   ___Copy of Degree(s)
___Completed W9                                            ___Resume/Curriculum Vitae
___Current license(s)

Please return all documents to: Attn: EAP Clinical Manager
1240 Pennsylvania NE, Suite C
Albuquerque, New Mexico 87110
or Fax to: 505-254-3535