

Matrix EAP Recredentialing Form

PLEASE PROVIDE THE MOST CURRENT COPY OF YOUR PSYCHOLOGICAL LICENSE AND VERIFICATION OF MALPRACTICE COVERAGE.

Provider Name:

LAST FIRST MI DEGREE

E-Mail Address: _____ Languages Spoken: _____

Primary Location

Secondary Location

Name: _____	_____
Address: _____	_____
City, State, Zip: _____	_____
Telephone: _____	_____
Cell Phone: _____	_____
Tax ID#: _____	_____
Office Contact: _____	_____

1. Has your license to practice ever been denied, restricted, limited, suspended, or revoked, or have you been reprimanded by a licensing agency? Yes/No _____
2. Have any complaints been filed against you? Yes/No _____
3. Are you now being treated for alcoholism or drug addiction? Yes/No _____
4. Do you have any felony/misdemeanor charges pending against you other than traffic violations? Yes/No _____
5. Have you ever been or are you now under investigation by a regulatory agency (e.g. Medicare, State Health Department)? Yes/No _____
6. Have any malpractice judgments been entered against you? Yes/No _____
7. Have any malpractice settlements been made or are any suits pending? Yes/No _____

****If you have answered yes to any of the above questions and have never answered yes to it before (i.e.—on application or previous recredentialing form), please attach explanation.**

From time to time Matrix is asked to send a provider to an employer’s site for counseling regarding issues such as difficult terminations, death of a coworker, etc. Would you like to be contacted for such referrals? ___Yes ___No
If yes, please briefly describe your training and experience in this area.

****Please continue on to Page 2 of this form****

Type of Practice:

Check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Academic Performance | <input type="checkbox"/> ACOA | <input type="checkbox"/> Alcohol/Substance Abuse |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anger Management |
| <input type="checkbox"/> Career Issues | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Bipolar Disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Chronic/Terminal Illness |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Geriatric Issues |
| <input type="checkbox"/> Gay/Lesbian Issues | <input type="checkbox"/> Gender Identity | <input type="checkbox"/> Marital/Couples |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Multi-Cultural Issues |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Men's Issues | <input type="checkbox"/> OCD | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Parenting Skills | <input type="checkbox"/> Personality Disorders | <input type="checkbox"/> Postpartum Depression |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> PTSD | <input type="checkbox"/> Rape Issues |
| <input type="checkbox"/> Sexual Abuse/Incest | <input type="checkbox"/> Sexual Disorders/Dysfunction | <input type="checkbox"/> Sexual Orientation |
| <input type="checkbox"/> Sexual Perpetrators | <input type="checkbox"/> Stress Management | <input type="checkbox"/> Testing |
| <input type="checkbox"/> Women's Issues | <input type="checkbox"/> Work Issues | <input type="checkbox"/> Eating Disorders |

Please describe other types of clients seen that are not on the above checklist: _____

Age of Clients Seen: _____

Is your business wheelchair accessible? _____yes _____no

Do you identify yourself as a culturally diverse practitioner? _____yes _____no

If yes, please specify _____

Areas or Types of Clients you prefer **NOT** to see:

I wish to continue as a provider in the Matrix EAP Network. I hereby certify that all information contained in this recredentialing form is complete and accurate to the best of my knowledge. I give permission for Matrix to confirm any areas of concern and will release information to them accordingly.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Name (Please Print): _____

**Please return this form to: MATRIX, Attn: Maryann Brandes, 2 Easton Oval, Suite 450, Columbus, OH 43219
800-886-1171/Fax 614-416-9800**

**PLEASE REMEMBER TO ENCLOSE A COPY OF YOUR CURRENT LICENSE AND
MALPRACTICE INSURANCE**