*Life*Solutions CLINICIAN PROFILE

Applicant Name: _____ License: PhD _____ LSW _____ Other _____

Certifications: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Mailing Address: _____

E-mail Address: _____ Years of Post-Master's Clinical Experience: _____

LOCATION AND HOURS

Primary Office Location *(if different from above)*: _____

_____

Primary Office Phone #: _____ Primary Office Fax #: _____ Primary Office Hours: _____

Secondary Office Location *(if applicable)*: _____

_____

Secondary Office Phone #: _____ Secondary Office Fax #: _____ Secondary Office Hours: _____

After-Hours/Emergency Phone #: _____ Answering Service: _____

Cell Phone/Pager: _____

Please indicate how many referrals per month you could accommodate from *Life*Solutions in your practice: _____

Private waiting room and entrance Yes _____ No _____
Separate entrance and exit Yes _____ No _____
Client records secured under lock and key Yes _____ No _____

INSURANCE

Professional Liability Insurance Carrier: _____

Address: _____

Telephone #: _____ Limits: _____ Expiration: ___/___/____

Have judgments or settlements been made against you by professional or licensure organizations in liability or ethics cases or are there any pending? Yes _____ No _____ *(If yes, please give details on a separate sheet.)*

LICENSURE

Licensure: State: _____ Number: _____ Expiration: ___/___/___

Federal Tax ID #: _____ State Licensing Board Telephone Number: _____

Prior EAP Experience *(Explain.)*: _____

Management Consultation and Training: _____

Are you a current provider for other EAPs? *(Please list.)* _____

Are you a certified Woman/Minority Owned Business Enterprise? _____

Are you a certified Substance Abuse Professional? _____

Are you a certified Employee Assistance Professional? _____

Are you a Christian-based Counselor? _____

DISCIPLINARY ACTION

Have you had your clinical privileges at any institution suspended, revoked, or reduced during the past year? Yes _____ No _____
(If yes, please provide an explanation of the reason why and identify the institution where this action occurred.)

COVERAGE INFORMATION

Clinician Backup *(individual filling in for you in the event of your absence)*: _____

Name: _____ Address: _____

Telephone #: _____ Consulting Psychiatrist: _____

Name: _____ Address: _____

Telephone #: _____

EXPERTISE OR SPECIAL SKILLS (*Please see Key Information Areas.)*

ATTACHMENTS

The following items need to be included in order for your application to be processed.

- ❑ Photocopy of current License(s)
- ❑ Photocopy of your current Substance Abuse Professional Certificate
- ❑ Photocopy of your current Women/Minority Owned Business Certificate
- ❑ Photocopy of your current Certified Employee Assistance Professional Certificate
- ❑ Photocopy of any other certifications (please specify): _____
- ❑ Photocopy of Academic Diploma
- ❑ Photocopy of current professional Liability Coverage Certificate, indicating Coverage Amounts and Effective Dates
- ❑ Photocopy of your current Curriculum Vitae

ATTACHMENTS FOR CLINICIAN BACKUP

The following items need to be included in order for your application to be processed.

- ❑ Photocopy of current License(s) or Certificate(s)
- ❑ Photocopy of current professional Liability Coverage Certificate, indicating Coverage Amounts and Effective Dates

EMERGENCY RESOURCES

Occasionally, we may receive "after-hours" emergency calls that require immediate attention as indicated by our telephone assessment. Please assist us in having an up-to-date list of telephone numbers and names for the emergency resources you utilize. Please fill in the information below. Thank you.

1. Chemical Dependency Facility

Name: _____ Phone #: _____

2. Psychiatric Center (Inpatient)

Name: _____ Phone #: _____

3. Emergency Room (24 hr. MD availability)

Name: _____ Phone #: _____

4. Emergency Shelter for Battered Women and/or Children

Name: _____ Phone #: _____

5. Mobile Crisis Team

Name: _____ Phone #: _____

I represent that the information contained in the foregoing application and attachments is true and complete to the best of my knowledge and belief, and I agree to inform UPMC *Life*Solutions promptly if any material change in such information occurs.

_____

Name *(Printed)* Degree

_____

Name *(Signature)* Date

KEY INFORMATION AREAS

Please check the appropriate information box in each category located in the left-hand column.
This will enable us to get to know you better and for us to serve our clients' needs more efficiently.

(*Please check appropriate boxes.)*

CLIENTS YOU SEE

- ❑ Children
- ❑ Adolescents
- ❑ Adults
- ❑ Seniors

TREATMENT MODALITIES YOU USE

- ❑ Individual
- ❑ Couples
- ❑ Family
- ❑ Groups

LOCAL RESOURCES OF WHICH YOU HAVE KNOWLEDGE

Psychiatric

- ❑ Inpatient
- ❑ Outpatient
- ❑ Respite/Holding Beds
- ❑ Structured Outpatient
- ❑ Partial Hospitalization/Day Treatment
- ❑ Partial Hospitalization/Evening Treatment
- ❑ Residential/Day Care
- ❑ Adolescent Residential
- ❑ After Care
- ❑ Psychiatric Consultation/Evaluation

Alcohol/Chemical Dependency

- ❑ Alcohol - Inpatient
- ❑ Alcohol - Outpatient
- ❑ CD - Outpatient
- ❑ CD - Outpatient Detox
- ❑ CD - Inpatient
- ❑ CD - Free Standing Rehab
- ❑ Respite/Holding Beds
- ❑ Structured Outpatient Program
- ❑ Partial Hospitalization/Day Treatment
- ❑ Partial Hospitalization/Evening Treatment
- ❑ Residential/Day Care

LANGUAGES SPOKEN

- ❑ English
- ❑ Spanish
- ❑ French
- ❑ German
- ❑ Japanese
- ❑ Chinese
- ❑ Russian
- ❑ Italian
- ❑ Vietnamese
- ❑ Portuguese
- ❑ Mandarin
- ❑ Hebrew
- ❑ Sign Language
- ❑ Other

YOUR CLINICAL SPECIALTIES

- ❑ AIDS
- ❑ ACOA
- ❑ ADHD
- ❑ Adolescent Adjustment Disorder
- ❑ Alcohol Abuse
- ❑ Anxiety Disorders
- ❑ Assertiveness
- ❑ Borderline Personality Disorder
- ❑ Career Counseling
- ❑ Chronic Illness
- ❑ Codependency
- ❑ Conduct Disorders
- ❑ Eating Disorders
- ❑ Enuresis/Encopresis
- ❑ Family/Child Issues
- ❑ Family Violence
- ❑ Financial
- ❑ Gambling
- ❑ Gay/Lesbian Issues
- ❑ Geriatric
- ❑ Grief/Major Loss
- ❑ Incest
- ❑ Legal
- ❑ Major Psychiatric Illness
- ❑ Marital/Divorce/Separation
- ❑ Medical/Physical Problems
- ❑ Men's Issues
- ❑ Phobias
- ❑ Physical Abuse
- ❑ Psychosomatic Illness
- ❑ PTSD
- ❑ Racial Issues
- ❑ Rape
- ❑ Religious/Spiritual Issues
- ❑ Retirement
- ❑ Sexual Abuse
- ❑ Sexual Addiction
- ❑ Sexual Harassment
- ❑ Sleeping Disorders
- ❑ Social Service Needs
- ❑ Spending
- ❑ Suicide
- ❑ Drug Abuse
- ❑ Women's Issues
- ❑ Work Induced Stress
- ❑ Workers' Comp
- ❑ Other *(specify)*

SPECIAL PROVISIONS OF YOUR OFFICE

- ❑ Handicap Access
- ❑ Public Transportation Access
- ❑ TDD/TTY

YOUR CLINICAL TECHNIQUES/SKILLS

- ❑ Acupuncture
- ❑ Analytic
- ❑ Cognitive/Behavioral
- ❑ Biofeedback
- ❑ Critical Incident Debriefing
- ❑ Family Systems
- ❑ Gestalt
- ❑ Hypnotherapy
- ❑ Neuropsych Testing
- ❑ NLP
- ❑ Organizational Training/Consulting/ Development
- ❑ Psychological Testing
- ❑ Psychopharmacology Evaluation and Management
- ❑ Parent Training
- ❑ Relaxation Techniques
- ❑ Stress Management
- ❑ Career/Vocational Counseling
- ❑ Supervisor Training
- ❑ Motivational Interviewing
- ❑ Brief Solution Focused Techniques
- ❑ Others *(Please list below.)*

***Life*Solutions**
U.S. Steel Tower
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