

## 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
- Eneuresis/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.)



## LifeSolutions 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 Hours: \_\_\_\_\_

Secondary Office Location (if applicable): \_\_\_\_\_

Secondary Office Phone#: \_\_\_\_\_ Secondary Office Hours: \_\_\_\_\_

After-Hours/Emergency Phone #: \_\_\_\_\_ Answering Service: \_\_\_\_\_

Cell Phone/Pager: \_\_\_\_\_

Please indicate how many referrals per month you could accommodate from LifeSolutions 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 judgements 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.)

**LifeSolutions**  
112 Washington Place Suite 400  
Two Chatham Center  
Pittsburgh, PA 15219

## 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? \_\_\_\_\_

## 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 *LifeSolutions* promptly if any material change in such information occurs.

\_\_\_\_\_  
Name (*Printed*) Degree

\_\_\_\_\_  
Name (*Signature*) Date