

AGENCY INFORMATION

Please list information on your agency as a whole and return to the address listed below with the necessary documentation.

1) Agency/Group name: _____

2) Private Practice? _____ Yes _____ No

3) Main office address: _____

_____ County: _____

4) Main telephone # of practice: _____

5) Main fax # of practice: _____

6) E-mail (if applicable): _____

7) Do you have any clinicians on staff who are trained to do CISD (Critical Incident Stress Defusing/Debriefing) and would be able to assist us in an emergency situation?

_____ Yes _____ No

8) Do you have any clinicians on staff who are trained to do SAP evaluations (Substance Abuse Professional)? *These evaluations are not covered under EAP.*

_____ Yes _____ No

9) Please list contact information for your agency if we have any questions or concerns.

Name/Title _____

Phone _____ Extension _____ Fax _____

10) Please list any additional offices your practice maintains. (Use a separate sheet if necessary.)

Address: _____

Phone (if different): _____ Fax (if different): _____

Address: _____

Phone (if different): _____ Fax (if different): _____

Address: _____

Phone (if different): _____ Fax (if different): _____

Address: _____

Phone (if different): _____ Fax (if different): _____

If you have more than one location, referrals should be directed to:

_____ Main office number _____ Individual office where client will be seen

MAIL to: Mazzitti & Sullivan EAP Services, 3207 N. Front Street, Harrisburg, PA 17110
or FAX to: 717-901-5659