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 as a Substance Abuse Professional (SAP) and can provide assessments for CDL-related violations? *These evaluations are <u>not</u> 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): ____________________

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

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