NASW Assurance Services, Inc. – EAPrefer - Employee Assistance Program (EAP) Network Application - *(Type or legibly print application in ink)*

Member Information

NASW Member ID#	Date of Birth (optional) ____/_____/_____	Gender (optional) ☐ M ☐ F ☐ T ☐ Other

Prefix	Last Name	First Name	Middle Name	Suffix	Designations (up to 3)

Preferred Address (we will send mail to this address)	City	State, Zip code

Home Phone and/or Cell Phone (this number will be used by EAP Administrators to contact you for case referrals)	Email (the majority of EAP Administrator use email to refer cases)

Preferred method for communication with the EAP network providers: ☐ Cell Phone ☐ Home Phone ☐ Business Phone ☐ Fax ☐ Email	Preferred method for communication with EAPrefer ☐ Cell Phone ☐ Home Phone ☐ Business Phone ☐ Fax ☐ Email

Ethnicity:
☐ American Indian or Alaskan Native ☐ Asian American or Pacific Islander ☐ African American/Black ☐ Hispanic/Latino
☐ White/Caucasian, Non Hispanic ☐ Chicano/Mexican American ☐ Puerto Rican ☐ Other_____

Insurance Information

Insurance Carrier	Per Claim Amount and Aggregate Amount	Expiration Date ____/_____/_____

Degree and Licensing Information **(Please provide specific licensing information to practice in your state as Employee Assistance Professional, i.e. LCPC, LPC, LCSW, LISW. For additional information about licensing requirements in your state please visit www.aswb.org)**

Highest Degree in Social Work ☐ BSW ☐ MSW ☐Doctorate/PhD SW	College/University	Graduation Date	Specialty

License Type and #	License Type and #	License Type and #
License State	License State	License State
License Expiration Date ____/_____/_____	License Expiration Date ____/_____/_____	License Expiration Date ____/_____/_____

Initial/Recertification Date ____/_____/_____	Expiration Date ____/_____/_____

EAP Experience

EAP Qualified Counselor: ☐ Yes ☐ No Years of Experience: ☐ None ☐ 1 to 3 years ☐ 3 to 5 years ☐ 5 to 10 years ☐ 10 plus years	**Training Qualified Professional**: ☐ Yes ☐ No Years of Experience: ☐ None ☐ 1 to 3 years ☐ 3 to 5 years ☐ 5 to 10 years ☐ 10 plus years
Treatment Provider: ☐ Yes ☐ No Years of Experience: ☐ None ☐ 1 to 3 years ☐ 3 to 5 years ☐ 5 to 10 years ☐ 10 plus years	**Critical Incident Response**: ☐ Yes ☐ No Years of Experience: ☐ None ☐ 1 to 3 years ☐ 3 to 5 years ☐ 5 to 10 years ☐ 10 plus years
Disaster Response: ☐ Yes ☐ No Years of Experience: ☐ None ☐ 1 to 3 years ☐ 3 to 5 years ☐ 5 to 10 years ☐ 10 plus years	Are you currently working on EAP panels: ☐ Yes ☐ No
List all the EAP panels you are presently working on or have worked on:	

Certificate Information **(please provide three most current specialty certifications and credentials)**

Certificate Type and #, if applicable	Certificate Type and #, if applicable	Certificate Type and #, if applicable
Certifying Board	Certifying Board	Certifying Board
Certificate Expiration Date____/_____/_____	Certificate Expiration Date____/_____/_____	Certificate Expiration Date____/_____/_____

Training - Please use the space below to provide your training and experiences from the last three years. Include training dates, program title, program sponsor, location (city and state or "DL" to indicate distance learning education), and number of training hours. Please print legibly and spell out all acronyms.

If you prefer, you can attach a professional resume that includes training information. This document will be placed in your online profile.

Work History - Please list your last three employers. Include employer, contact name, phone, title and dates of employment. If in private practice, check here ☐

If you prefer, you can attach a professional resume that includes training information. This document will be placed in your online profile.

Practice Information

Group/Organization/Name	DBA (If different)		Primary Contact
Primary Practice Address	City		State, Zip code
Business Phone	Fax Number	Business Email	☐ Check here if your facility is ADA compliant
National Provider Identifier	Council for Affordable Healthcare (CAQH) Provider Identifier, if applicable		Minority& Women's Business Enterprises Certification #, if applicable

List all geographical areas in which you provide service, including additional practice locations
Language Spoken and % of fluency _____ _____ _____ _____
Work Focus: ☐ AIDS/HIV ☐ Alcohol/Drug Abuse ☐ Conflict Resolution ☐ Dev/Other Disabilities ☐ Employment Related ☐ Family Issues ☐ Grief Bereavement ☐ Health ☐ Housing ☐ Income Maintenance ☐ Individual/Behavioral Problems ☐ International ☐ Other_____ ☐ Violence/Victim Services ☐ SA –Substance Abuse
Work Setting: ☐ Behavioral Health-Inpatient ☐ Behavioral Health-Outpatient ☐ Health-Inpatient ☐ Health-Outpatient ☐ Managed Care Organization ☐ Private Practice-Group ☐ Private Practice-Solo ☐ Other _____
Practice Area: ☐ Addictions ☐ Adolescents ☐ Aging ☐ Child Welfare/Family ☐ Crisis Intervention ☐ Critical Incident Response ☐ Developmental Disabilities/Rehabilitation ☐ EAP/Occupational Social Work ☐ Health ☐ Mental Health ☐ Other_____ ☐ Pediatrics ☐ Public Health ☐ Veterans ☐ Violence
Do you accept insurance: ☐ Yes ☐ No Please list all insurance you accept:

I certify that I am a member in good standing of the National Association of Social Workers and that I abide by the NASW Code of Ethics and the NASW Standards for Continuing Professional Education. I hereby certify that the information contained herein is true, accurate and complete. I understand that any information that is found to be false could be cause for denial of participation in the Network and could result in termination of any agreement I may enter into with an EAP Provider. I understand and agree that an electronic signature shall be as effective as a written signature and a facsimile or photocopy as effective as the original.

Name (print): _____ Member ID#: _____

Signature: _____ Date: _____

NASW Assurance Services (NASWASI) EAP Network Applicant

Disclosure Questions

Please answer all questions. If you answer **YES** to any question, please provide details on a separate sheet sign and date each sheet.

Professional Sanctions:

1.	Has your license, registration or certification to practice any profession in any jurisdiction ever been voluntarily or involuntarily relinquished, withdrawn, denied, suspended, revoked, restricted, or have you been fined, reprimanded, subject to a consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?	Yes__ No__
2.	Have you ever been subject to disciplinary action, formal or informal, by an ethics committee, licensing board, professional association or educational institution?	Yes__ No__
3.	Have your clinical privileges at any hospital or healthcare institute ever been denied, suspended, revoked or restricted, or your participation in any managed care organizations (HMOs/PPOs) or providers organizations (IPAs/PHOs) ever been terminated or not renewed for cause, or have you been subject to any disciplinary action?	Yes__ No__
4.	Have you ever been disciplined, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in participating in Medicare, Medicaid, or any other federal or state governmental healthcare plans or programs?	Yes__ No__
5.	To your knowledge has information about any complaints involving you ever been reported to any state, federal, national data bank, or state licensing or disciplinary entity?	Yes__ No__

Professional Liability Insurance and Claims History:

6.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (i.e. reduced limits, restricted coverage, surcharges)?	Yes__ No__
7.	Have allegations or claims of professional negligence or unprofessional conduct been made against you at any time, whether or not you were individually named in the claim or lawsuit and whether or not such claims are pending or were settled, arbitrated, mediated or litigated	Yes__ No__
8.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	Yes__ No__
9.	Are any of the services that you are providing NOT covered by your current malpractice coverage?	Yes__ No__

Criminal and Civil History:

10.	Have you within the last 10 years been convicted of, pled guilty to or pled no contender to a crime or are any criminal charges currently pending against you?	Yes__ No__
11.	Are you currently, or have you in the past 10 years been, the subject of an investigation by any private, federal or state entity, or a defendant in any civil action, that is reasonably related to your qualifications, competence, functions, or duties as a social worker?	Yes__ No__

I hereby certify that all the statements made on this form and on any attached information sheets are complete, accurate and current. I understand that any misstatements in or omissions from this statement constitute cause for denial of participation in the NASWASI EAP Network or cause for summary termination of any agreement I may enter into with a designated Employee Assistance Program. I understand that I am responsible for notifying NASWASI within 10 days of any changes to the information contained herein and on any attachment. I understand and agree that an electronic signature shall be as effective as a written signature and a facsimile or photocopy as effective as the original.

Name (print): _____ Member ID# _____

Signature: _____ Date: _____

NASW Assurance Services (NASWASI) EAP Network Applicant
Attestation, Acknowledgement and Indemnification

By signing below (may be a written or electronic signature), I hereby certify that all of the information contained in this application and attachments is true, complete, accurate and current. I understand that NASWASI will not be independently verifying this information and that I am solely responsible for the accuracy of the information I provide. I will notify NASWASI, or its designee, within 10 days of any changes in the information I have provided, any challenges to licensure, malpractice claims, criminal convictions, or other disciplinary actions. I understand that I will have online access to the database to make changes in the information contained therein.

I understand that ASI will make the information submitted herewith available to Employee Assistance Program (EAP) providers and I consent thereto. I acknowledge the EAP providers will rely on the accuracy of the information. I understand that the EAP providers are solely responsible for selecting, contracting with and paying participants in the NASWASI EAP Network. I understand and agree that any services I perform will be pursuant to a separate independent contractor agreement with the EAP Provider and that utilization of my services by an EAP Provider will not result in my employment by the EAP Provider.

I understand that submission of this application does not guarantee my inclusion in the NASWASI EAP Network, and that inclusion in the Network does not guarantee that my services will be used by any designated EAP provider. I further understand that any misstatement or omission of information, or failure to promptly update information, may result in my removal from the Network and termination of any agreement with an EAP provider. I hereby release from all liability and hold harmless NASW Assurance Services (NASWASI) and the National Association of Social Workers (NASW), their officers, directors, employees and agents, for their acts performed in good faith and without malice in connection with the gathering and release of, and reliance upon, information provided in connection with the Network application and in accordance with this attestation, acknowledgement and indemnification.

I hereby indemnify and agree to hold harmless NASWASI and NASW, their officers, directors, employees and agents, from any and all claims, demands, suits, liabilities, fines or judgments, including reasonable attorneys fees, costs and expenses, asserted or awarded against or incurred by NASWASI or NASW, and/or their officers, directors, employees or agents, by reason of or arising out of or in connection with any information or statements provided by me, the application process, my inclusion in the NASWASI EAP network or the utilization of my services by an EAP provider.

I HAVE READ AND UNDERSTAND THE FOREGOING ATTESTATION, ACKNOWELDGMENT AND INDEMNIFICATION.
I understand and agree that an electronic signature shall be as effective as a written signature and that a facsimile or photocopy of this attestation, acknowledgment and indemnification shall be as effective as the original.

Name (print): _____ Member ID# _____

Signature: _____ Date: _____

Employee Assistance Program (EAP) Network Electronic Signature Acknowledgement

Applicant acknowledges and agrees that by clicking on the button labeled “I Agree” or such similar links as may be designated by NASWASI to submit this application, applicant is submitting a legally binding electronic signature and is entering into a legally binding agreement. Applicant acknowledges that applicant's electronic submissions constitute applicant's certification and attestation to the accuracy of the information provided and intent to be bound by the terms set forth in the application. Pursuant to any applicable statutes, regulations, rules, ordinances or other laws, including without limitation the United States Electronic Signatures in Global and National Commerce Act, P.L. 106-229 (the “E-Sign Act”) or other similar statutes, applicant HEREBY AGREES TO THE USE OF ELECTRONIC SIGNATURES, CONTRACTS, ORDERS AND OTHER RECORDS AND TO ELECTRONIC DELIVERY OF NOTICES, POLICIES AND RECORDS OF TRANSACTIONS INITIATED OR COMPLETED THROUGH THE SOFTWARE OR SERVICES OFFERED BY NASWASI. Further, applicant hereby waives any rights or requirements under any statutes, regulations, rules, ordinances or other laws in any jurisdiction which require an original signature or delivery or retention of non-electronic records, or to payments or the granting of credits by other than electronic means.