Employee & Family Resources, Inc.®

Prospective Network Provider

Practice Name:_____ Date:_____

Contact Person: _____Title: _____

Phone: _____Fax:_____ _____

Email: _____Website: _____

Mailing Address:_____

Clinical Address (s):_____

_____

_____

Days/hours of appointment availability:_____

Are your offices handicapped accessible? ____Yes ____No

Does your practice have experience serving culturally diverse populations? ____Yes ____No

If yes, please specify: _____

Does your practice include any bilingual clinicians? ____Yes ____No

If yes, please specify language(s): _____

Does your practice have experience providing EAP services? ____Yes ____No

Does your practice have experience providing substance abuse assessment? ____Yes ____No

Does your practice provide Critical Incident Stress Debriefing? ____Yes ____No

Does your practice provide federal DOT Substance Abuse Prof evaluations? ____Yes ____ No

Is your practice interested in providing training services to companies? ____Yes ____ No

If so, what type:_____

_____

Mail, fax, or email this request to:
Provider Relations
Employee & Family Resources
505 5th Avenue, Suite 600
Des Moines, IA 50309-2319
Fax (515) 284-5201
ProviderRelations2@efr.org