

EAP/Affiliate/Counsellor Application Form

Name: _____

Address: _____

E-mail: _____

Primary Phone Number: _____

CISD trained (please circle) Y / N

Languages spoken: _____

Your ethnic origin: _____

Specializations:

Please tick (✓)

- Anxiety Disorders:
- ADHD/ADD:
- Alcohol/Drugs:
- Biofeedback:
- Bereavement:
- Career Issues:
- Child Abuse Issues:
- Child/Adol. Disorders:
- CISD:
- Christian/Spiritual:
- Cult Issues:
- Developmental Disorders:
- Domestic Violence:
- EAP Training:
- Eating Disorders:
- Family:
- Financial/Budget:
- Fitness for Duty Evals:
- Gambling:
- Group:
- Incest/Sexual abuse:
- Learning disabilities:
- Work Issues:

- Legal:
- Marital/Couples:
- Mood Disorders:
- Multi-cultural Issues:
- Mediation:
- Medical issues:
- Men's issues:
- OCD:
- Phobias:
- PTSD:
- Pain Management:
- Parenting:
- Perpetrators:
- Personality Disorders:
- Psychological testing:
- Psychoses:
- School/Education:
- Sexual orientation:
- Sexual Addiction:
- Sexual Disorders:
- Stress Management:
- Women's Issues:

Membership of associations:

Please tick (✓)

BABCP:
 BACP:
 BPS:

UKRC:
 UKCP:

Credentials:

Please tick (✓)

Diploma Counselling:
 B.Sc or B.A.
 M.Sc Counselling:
 M.Sc Social work:
 CEAP:
 MA Counselling:
 Psychology
 PhD:

Preferred Provider with Insurance Company:

Please tick (✓)

BUPA:
 Norwich Union:
 PPP:

Office Locations:

- Location Name:.....
 Street:.....
 City/Town:.....
 Post Code:.....
 Country:.....
 Contact person:.....
 Contact telephone:.....
 Fax number:.....

Liability:

Accreditation(s):

£

Expiry date: Type:
 Carrier/Insurer: Expiry:

Please send copies of your liability and accreditation certificates along with this application.