

Private and Confidential

Dear

RE: Affiliate Network Application

Please find enclosed as discussed the following documents for completion and return to:

Saunders Clinic, The Colchester Osteopathic Centre, 27 Oaks Drive, Colchester, Essex CO3 3QZ. or fax: 01206 814 741 or email: referrals@saunders-clinic.co.uk

- Application Form
- Network Agreement
- Official Secrets Act
- Application check list

You will also need to enclose photocopies of your current qualifications, accreditation, registration and professional indemnity insurance.

Please find below our expected service standard levels for the case management of clients referred to you.

If you should have any questions regarding any of the above please do not hesitate to contact us.

Kind regards,

p.p.

Pam Saunders-Ward
Managing Director

Enclosures: 4

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

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

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:

1. 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.

Dear,

As you may be aware, some of our clients work in sensitive occupations. As a consequence information regarding National Security may inadvertently be disclosed during therapy sessions.

Therefore, in order to continue working with our client base you are required to read information regarding the Official Secrets Act 1989.

http://www.opsi.gov.uk/acts/acts1989/ukpga_19890006_en_1

Please sign this letter to confirm that you have read the Official Secrets Act 1989 and abide to work within its boundaries.

I understand and agree to work within guidelines of the Official Secrets Act 1989.

Name:.....
(please print)

Signed:.....

Date:.....

Many Thanks

<p>The Saunders Clinic is working in partnership with organisation, by providing brief CBT and Psychological services on a national basis for their clients. Please ensure service levels detailed are met – thank you.</p>	
<p>Counsellor/Therapist to acknowledge receipt of referral and advise of 1st appointment date.</p>	24 hours
<p>Please telephone the Saunders Clinic after each session to advise of next appointment scheduled and provide a brief update. 01206 814 740</p>	1 working day
<p>Initial assessment – client must be seen.</p>	within 10 working days
<p>Initial Assessment Report to be emailed to the Saunders Clinic – please ensure that all fields are completed including psychometric test results, interventions and client goals. referrals@saunders-clinic.co.uk</p>	within 10 working days

<p>Progress reports only to be used if client has more than 6 sessions. All fields must be completed including psychometric test results. Report to be emailed to the Saunders Clinic after 6th session or at 6 week point. referrals@saunders-clinic.co.uk</p>	<p>within 3 working days</p>
<p>Discharge – closure reports to be emailed to the Saunders Clinic after final session. Please ensure all fields are completed including goals achieved and psychometric test results. referrals@saunders-clinic.co.uk</p>	<p>within 3 working days</p>
<p>Please complete Authorisation for Service Form(s) and return with SC payment request form to the Saunders Clinic after the final session. If these are not submitted your payment will be delayed until they are received.</p>	

*High Risk clients – if at anytime you believe your clients risk level has changed please contact 0845 601 8346 - 24 hours.

Thank you
If you have any questions or queries during the process
please contact 01206 814 740.

Application Check List

- Network Agreement – Signed
- Official Secrets Act – Signed
- Copies of:
 - Qualifications
 - Accreditation(s)
 - Registration(s)
 - P I Insurance
- Post – correct postage
- Email: referrals@saunders-clinic.co.uk
- Fax: 01206 814 741