

**\*\*\*\*Please enclose the following documents when mailing this application to  
The Sand Creek Group, Ltd.\*\*\*\***

**Checklist**

- Completed Individual Packet(s)
- Completed W-9 form (Only if payment is made directly to the individual – If payment goes to the group, this form is already on file).
- Current Professional Liability Insurance Face Sheet (Only if the individual is *not* covered by his or her group's liability insurance).
- Copy of current state licenses and/or certification, including number.
- Resume
- EAP certificate (if applicable).
- Individual application for inclusion in the SAP network (if applicable).
- Individual application for inclusion in the critical incident stress management network and training certificate (if applicable).

PLEASE RETURN COMPLETED INFORMATION TO:

**The Sand Creek Group, Ltd.  
610 North Main Street, Suite 200  
Stillwater, MN 55082  
Attn: Kylie LaFontaine, National Network Coordinator  
Phone (651) 430-3383  
Fax (651) 430-9753**

## **SECTION II: Individual Applicant Information**

### **Personal demographics**

Legal Name: \_\_\_\_\_ Birth Date (mm/dd/yyyy): \_\_\_\_\_

Gender:  Male  Female

Total number of years post-Masters degree clinical experience:.....

Total number of years Employee Assistance experience:.....

Do you work in a clinical practice for a minimum of 10 hours/ week? (total hours in all practices)  Yes  No

Do you receive supervision or consultation?..... Yes  No  
If yes, indicate number of supervision or consultation hours you receive per month:.....

Do you keep records of all training/education you receive and are you able to make these available to us and/or external reviewers upon request?..... Yes  No

The following information regarding sexual orientation, religious affiliation, and race/ethnic group is not used for purposes of denying an application for participation. Often clients will ask for a counselor who meets specific criteria within one of the following categories. If your application is approved, and you provide this information, your response will be entered into our database so that you can be identified if a client requests a counselor who meets a specific category. Any responses you provide or your decision to not provide this information will not, in any way, be the basis for denying your application for participation.

Would you be willing to identify your sexual orientation in our database for clients that request an EAP counselor with your specific orientation?..... **Yes**  **No**

If yes, check all that apply:

Heterosexual  Bisexual  Gay/ Lesbian  Transgender

Would you be willing to identify your religious background in our database for clients that request an EAP counselor with your specific religious background?.... **Yes**  **No**

If yes, check all that apply:

Catholicism  Christianity  Eastern Religion  Islam  Judaism  Other: \_\_\_\_\_

Would you be willing to identify your ethnic background in our database for clients that request an EAP counselor with your specific background?..... **Yes**  **No**

If yes, check all that apply:

African American  Asian, Pacific Islander  Caucasian  
 Arab/Arabian  Native American  Hispanic  Other: \_\_\_\_\_

Would you be willing to identify your military experience in our database for clients that request an EAP counselor with your specific background?..... **Yes**  **No**

If yes, are you a Veteran?..... Yes  No

Special Disabled Vet.  Vietnam Era Vet.  Newly Separated Vet.  Other Protected Vet.

**Employment History (Attach current resume or vitae)**

(Work history must include at least the most current 5-year period, including present employment. Attach supplemental pages for additional employer information and explanations for any gaps in employment over last 5 years.)

Name of Employer Organization Office Practice	City, State	Phone Number	Position	Dates	Manager's Name

**License/Certification Information (Attach copy(s) of all current licenses and/or certifications.)**

Type of license/certification	State	Date of License/Certification	License Number	Status A=Active I=Inactive S=Suspended	Expiration Date

**Professional Education**

Type U =Undergraduate P =Prof./Graduate I =Internship O = Other	Name of Institution	Mailing Address	Degree	Dates (From-To)	Graduation Date

**Liability Information**

Complete all the information below and attach a copy of current malpractice/ professional liability insurance face sheet that lists liability limits and individual name(s). **\$1 Million/\$3 Million required.**

\_\_\_\_\_  
Name of Agent/Carrier for Professional liability / malpractice insurance

\_\_\_\_\_  
Address City State Zip

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Coverage limits: \_\_\_\_\_ Amount Per Occurrence: \_\_\_\_\_

Aggregate: \_\_\_\_\_

**Individual office locations and hours**

What hours and offices are clients seen for in-person appointments with you individually:

Day	Hours	Location	Hours	Location
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

**EAP Experience**

1. I have experience providing Employee Assistance counseling.....  Yes  No
2. I am qualified and experienced in providing solution-focused counseling.....  Yes  No
3. I am qualified to provide general assessments, short-term problem-resolution counseling, and/or referrals for:
  - a. Mental Health.....  Yes  No
  - b. Family, Children Within Family Context, & Relationship.....  Yes  No
  - c. Alcohol/ Drug Addiction.....  Yes  No
4. I am experienced in identifying and resolving workplace problems that may be caused and/or exacerbated by an employee’s personal or work life.....  Yes  No
5. I am experienced in helping employees understand and resolve conflict at work.....  Yes  No
6. I have experience and understanding of dual-client relationships\*.....  Yes  No
7. I have knowledge of community resources and local treatment providers.....  Yes  No
8. I have knowledge and experience with assessing and managing high-risk situations (e.g. suicidal, homicidal, self-injury).....  Yes  No
9. I am experienced in providing services for work-mandated cases.....  Yes  No

\* Dual-client relationships: You are simultaneously serving both the client, recipient of sessions, and the client company, payer of the service.

**CLINICAL PREFERENCES/EXPERTISE** (Check all that apply.)

**Clientele served**

- Adolescent/Teen
- Adult
- Children
- Family
- Group

**Languages**

List any that you are able to provide counseling in: \_\_\_\_\_

**Individual Specialties**

- ADD/ADHD
- Addictions, Non-Chemical
- Anger Management
- Anxiety
- Career Concerns
- Christian Counseling
- Depression
- Domestic Violence
- Eating Disorders
- Elder Care Issues
- Financial
- Gambling
- GLBT
- Grief Loss
- Health/Medical Issues
- Mandatory Workplace Referrals
- Marital/Couples Counseling
- Military Experience or Working with Military Population
- Personality Disorders
- PTSD, Post Traumatic Stress Disorder
- Retirement
- Sexual Abuse
- Spiritual Counseling
- Substance Abuse/Alcohol and Drug Counseling
- Training, employee orientation, presentation experience

**EAP Provider Relationships**

Please list those EAP Organizations you are approved to provide services for:

**Insurance Provider Relationships**

Please list those insurance providers you are approved to provide third party billing services for:

## Statement

If you answer “YES” to any of the following questions, provide: (1) a detailed explanation of your involvement, (2) the date the action was initiated, (3) the current status, including any final outcome, (4) amount of judgment/settlement or adverse decision, AND (5) a copy of any court order, consent order and findings, settlement agreement or other documentation regarding the current status or final resolution for each matter. If a matter is pending, include a letter from your attorney providing detailed information regarding current status of the matter and copies of any related documentation such as an indictment, statement of charges, Summons & Complaint, Answer, etc.

Have you ever been charged or convicted of a misdemeanor related to your professional functions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been charged or convicted of a felony in any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been investigated by any professional or licensure board, professional association, private payer, state or federal regulatory agency, or other authority?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your clinical license, certification, or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way by a licensing agency or any other regulatory bodies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever voluntarily relinquished your professional license, certification or other authority to practice for any reason, including as an alternative to disciplinary action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any formal disciplinary or criminal charges pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any complaints against you filed with any licensing, certification, or other regulatory body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has it ever been determined that you have operated outside the recognized boundaries of your professional competencies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your employment, hospital privileges, managed care organization or EAP participation, or other privileges or participation status every been denied, restricted, suspended, reduced, revoked, not renewed, placed on probation or otherwise limited in any way?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been involuntarily terminated from professional employment or a hospital staff, or, terminated by a managed care organization, an EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever resigned with knowledge of an investigation about you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any disciplinary actions that have been initiated against you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any complaints against you filed with a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you now or have you ever been sanctioned or excluded from federal, state or local government programs, including but not limited to Medicare and Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been expelled from or disciplined by any professional association or organization not included in any other question?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any physical or mental condition, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in anyway poses a risk of harm to your clients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently engaged in the illegal use or abuse of drugs or controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have any malpractice suits, professional liability suits, arbitration or other proceedings ever been instituted against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a professional liability carrier ever denied, limited, not renewed, or canceled your coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a non-professional relationship with a client or former client that was sexual in nature or otherwise in violation of any ethical rules of your profession?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Attestation Statement and Authorization**

All information submitted by me in this Application, as well as any attachments or supplemental information, is true, current, and complete to the best of my knowledge and belief as of the date of the signature below. I fully understand that any information provided during the application or recredentialing process is subject to The Sand Creek Group investigation and review. I understand that if any information contained in this Application is determined to be false or constitutes a material misstatement, my Application may be denied or my affiliate status may be terminated by The Sand Creek Group immediately. I further understand that in that event, The Sand Creek Group may be required to submit a report to state licensing authorities.

I understand The Sand Creek Group will request information from relevant local, state and federal licensing boards as a part of the application review process.

I acknowledge that I have completely read and fully understand this Application. I certify that all of the information contained in this Application and all of its attachments are complete, true and correct.

I agree to notify The Sand Creek Group in a timely manner (not exceed 30 days) of any changes to the information requested on the initial application.

Signature of Affiliate and/or Applicant: \_\_\_\_\_

Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize Sand Creek Group EAP to consult with any educational institution, board, other licensing or certification entities, former employer or any other professional organization, including past and present malpractice and/or professional liability carriers, who may have information bearing on my professional competence, character, or ethical qualifications. Upon request by The Sand Creek Group, I will obtain and provide to The Sand Creek Group documentation and materials pertaining to my qualifications and/or competence, including, but not limited to, any disciplinary action, suspension, or felony. I hereby consent to the inspection by The Sand Creek Group, or its representatives, of all documents that it determines to be material to this evaluation of my professional competence.

I hereby release from liability all individuals, institutions, and entities with which I have been or am associated, including but not limited to professional liability carriers, previous employers, clinics, hospitals, state licensing organizations, professional societies, and health plans to provide any relevant information requested by The Sand Creek Group or its representatives. In the event that I am accepted for participation in Sand Creek Group’s EAP Provider Network, I hereby consent to The Sand Creek Group’s inspection of my client records relating to The Sand Creek Group participants as necessary for its utilization, clinical quality programs, and complaint resolution processes. I understand and agree that the authorizations and releases given by me are irrevocable as long as I am an applicant for participation status with The Sand Creek Group or am participating in The Sand Creek Group’s EAP Provider Network.

I acknowledge that I have completely read and fully understand this Authorization and Release.

Signature of Affiliate and/or Applicant: \_\_\_\_\_

Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

## OPTIONAL SECTION: MANDATED SUBSTANCE ABUSE

To be completed by those applying for inclusion in our Mandated Substance Abuse Network

### EAP Mandated Substance Abuse, Network Criteria

- Bachelor’s, Master’s degree, or higher in counseling, social work, psychology, or a related mental health profession.
- Alcohol and Drug Counselor Certification or Licensure (or have proof of applicable specialized training).
- Confidential and secure fax.
- Malpractice/professional liability insurance: \$1,000,000 occurrence / \$3,000,000 aggregate.
- Professional office setting that ensures confidentiality.
- Minimum of 2 years of clinical experience working in outpatient or inpatient substance abuse treatment setting.

### Other Considerations: (Preferred, but not required)

- Certified Employee Assistance Professional.
- Office hours at least 4 days per week.
- Office hours at least one evening and/or weekend per week.
- Internet access in office setting with Internet Explorer browser 6.0 or higher.
- Ability to meet accessibility guarantees.

### Substance Abuse Experience:

1. I am qualified to conduct a chemical dependency assessment.....  Yes  No
2. I am qualified to provide substance abuse education and information services.....  Yes  No
3. I am qualified and willing to make treatment recommendations on all mandated referrals.....  Yes  No

Total number of years working in an outpatient/private practice or inpatient substance abuse treatment setting:.....

Substance Abuse Outpatient or Inpatient Treatment Positions	Company Name	Company Address	Dates	% of practice in Substance abuse
<input type="checkbox"/> Inpatient Outpatient Position:				
<input type="checkbox"/> Inpatient Outpatient Position:				
<input type="checkbox"/> Inpatient Outpatient Position:				

### Substance Abuse (SA) Services

- Detox
- Drinking/Drug Impaired Driver Programs
- Drug Testing
- In Patient SA Treatment
- Intake/Assessment
- Outpatient SA Treatment
- Perinatal Drug Treatment
- Public Inebriate Transportation
- Residential SA Treatment
- SA Crisis Intervention
- SA Education/Prevention
- SA Intervention Programs
- Transitional SA Services

### Substance Abuse Target Groups

- Adolescents
- Adults
- Aided Person
- Developmental Disability
- Educational Status
- Frail Elderly
- Functionally Disabled
- Health Conditions
- Homebound People
- Learning Disabilities
- Long Term Care Recipients
- Men
- Mental/Emotional Disturbance
- Physical Disabilities
- Senior Citizens
- Sexual Orientation / Gender Identity
- Terminal Illness
- Transients
- Victims/Survivors
- Visual Impairments
- Women

### Target Substance Abuse Groups

- Alcohol
- Cross Addiction
- Drugs
- Nicotine

### Twelve Step Mutual Support Groups

- Adult Children of Alcoholics (ACOA)
- Alcoholics Anonymous (AA)
- Al-Anon
- Alateen
- Gamblers Anonymous (GA)
- Co-dependency (CODA)
- Cocaine Anonymous (CA)
- Narcotics Anonymous (NA)

## OPTIONAL SECTION: SAP (SUBSTANCE ABUSE PROFESSIONAL)

To be completed by those applying for inclusion in our SAP Network

### Criteria: Substance Abuse Professional

- Licensed Physician (Doctor of Medicine or Osteopathy); or
  - Licensed or certified Psychologist; or
  - Licensed or Certified Employee Assistance Professional (LEAP, CEAP), or
  - Alcohol and Drug Counselor Certification Commission (NAACAC), or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC), by the National Board for Certified Counselors, Inc., and Affiliates/Mater Addictions Counselor (NBCC),
- 
- You must have knowledge of and clinical experience in the diagnosis and treatment of substance abuse related disorders.
  - You must understand how the SAP role relates to the special responsibilities employers have for ensuring the safety of the traveling public.
  - You must be well informed about Park 40, pertinent DOT agency regulations, these SAP guidelines, and any significant changes to them.
  - Add Malpractice Insurance information.
  - Ability to immediately return emergency phone requests.

### Training

Received qualification training:

- Training must include the nine required components laid out in Section 28 (c) of Part 40.
- You must have completed this training requirement by December 31, 2003, if you became a SAP on or before December 31, 2003, and submit proof of this
- If you became a SAP after December 31, 2003, you must meet the about training requirements before performing any SAP functions.
- You must have satisfactorily completed an examination, which was given by a nationally recognized professional or training organization (i.e., any training or professional organization giving this exam must have their SAP examination validated by a test evaluation organization.)
- During each three-year period following satisfactory completion of your training and examination, you must complete at least 12 professional development hours (e.g., Continuing Education Units) relevant to performing SAP duties.

### Other Considerations:

Forward to The Sand creek Group copies of the SAP forms you currently use. If they do not meet The Sand Creek Group's expectations of SAP documentation, The Sand Creek Group will supply its SAP pack with expectations that these forms will be used on the SAP's own letterhead.

### SAP Experience:

SAP evaluations you have experience with (Check all that apply)

- Federal Motor Carrier Safety Administration (FMSCA). Regulation 49 Part \_\_\_\_ (Fill in the correct number)
- Federal Railroad Administration (FRA) Regulation 49 Part \_\_\_\_ (Fill in the correct number)
- Federal Aviation Administration (FAA) Regulation 49 Part \_\_\_\_ (Fill in the correct number)
- Federal Transit Administration (FTA) Regulation 49 Part \_\_\_\_ (Fill in the correct number)
- United States Coast Guard (USCG) Regulation 49 Part \_\_\_\_ (Fill in the correct number)
- Research and Special Programs Administration (RSPA) Regulation 49 Part \_\_\_\_ (Fill in the correct number)

## OPTIONAL SECTION: CRITICAL INCIDENT STRESS MANAGEMENT

To be completed by those applying for inclusion in our CISM network Criteria: Critical Incident

### Stress Management

- Master's degree or higher in counseling, social work, psychology, or a related mental health profession
- State license/certification in area(s) of specialty, unrestricted
- Minimum of 2 years of onsite CISM related experience
- Minimum of 5 critical incident interventions within the last 2-year period
- Minimum of 2 critical incident interventions where applicant was the primary facilitator within the last 2-year period
- Malpractice/professional liability insurance: \$1,000,000 occurrence/\$3,000,000 aggregate
- Ability to immediately return emergency phone requests
- Specialized training in post-trauma intervention, preferably one of the following:
  - ICISF-Approved, Basic Critical Incident Stress Management Course
  - Board Certified Expert in Traumatic Stress through the American Academy of Experts in Traumatic Stress
  - Red Cross Certification
  - National Organization of Victim Assistance (NOVA) Certification
  - Federal Aviation Administration (FAA) Certification
  - Human Resource Management (AHR) Critical Incident Stress Debriefing Program
  - Other CISM models that are verifiable (subject to approval by Ceridian EAP & Life-Works Services)

### Other Considerations: (Preferred, but not required)

- Ability to meet accessibility requirements for CISM response within 24-72 hours
- Ability to meet accessibility requirements for CISM response within 2 hours
- Internet access in office setting with Internet Explorer browser 6.0 or higher

### Accessibility

Ability to be onsite to conduct critical incident interventions within 24-72 hours  Yes  No

Ability to be onsite to conduct critical incident interventions within 2 hours  Yes  No

Please provide cell phone or pager number: \_\_\_\_\_

### Critical Incident Stress Management Experience:

Types of critical incident interventions you have performed (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Robbery           | <input type="checkbox"/> One to One Counseling After Critical Incident at Work-Site |
| <input type="checkbox"/> Death of Employee | <input type="checkbox"/> Suicide  |
| <input type="checkbox"/> Downsizing        | <input type="checkbox"/> Terrorism  |
| <input type="checkbox"/> Natural Disaster  | <input type="checkbox"/> Other: _____   |

Total number years of CISM experience: \_\_\_\_\_

Total number of onsite critical incident interventions within the last 2 year period: \_\_\_\_\_

Total number of onsite critical incident interventions as the primary facilitator in the last 2 year period: \_\_\_\_\_

### CISM Training Information:

TYPE OF CISM TRAINING	NAME OF TRAINING INSTITUTION	CITY/STATE	PHONE	HOURS OF TRAINING	TRAINING COMPLETION DATE (M/DD/YY)