First Advantage, EAP Affiliate Evaluation Form
P.O. Box 1670 Bethesda, MD 20827
CONFIDENTIAL EVALUATION

TO BE COMPLETED BY APPLICANT:

____ ______________
Name of Applicant (Please print or type) Date

____
Name of Reference (Please print or type)

____
Address of Reference

____ ______________
City State Zip Code Phone #

Please indicate which of the clinical practice areas for which you are applying:

___SAP Substance Abuse Professional (assessment)
___EAP Employee Assistance Program (assessment, referral & brief treatment)
___CISD Critical Incident Stress Debriefing
___RTW Return to Work Program
___On-Site EAP Onsite Services
___Training Employee Orientation, Supervisory Training, Workshops, etc

I, the undersigned applicant, hereby release from liability and hold harmless for the consequences of any disclosure, to the fullest extent permitted by law, the above-named reference and First Advantage, EAP for their written and oral statements, decisions, and actions in connection with evaluating my application for clinical privileges, experience, credentials, qualifications, health status, emotional stability, professional ethics and character.

____ ______________
Applicant Signature Date

TO BE COMPLETED BY REFERENCE

The above named clinician has made application to be a network provider for **First Advantage, EAP**. Please take a few moments and complete this evaluation form as to his/her application relative to the clinical privileges indicated above.
Please mail to **First Advantage EAP**, P.O. Box 1670, Bethesda, MD 20827

How long have you known the applicant?____

Did you supervise the applicant in a clinical capacity? ______________________________

What is your current license? ______________________________ ______________
(Type of license) (State)

What is your present position? ____

Applicant Name ____________________________
(Please Print)

Does the applicant currently show any signs of drug or alcohol problems that would affect their professional performance? Yes_____ No _____

Does the applicant currently show any signs of mental or physical problems that would affect their professional performance? Yes_____ No_____

To your knowledge, has the applicant ever been under investigation by professional association or licensing board? Yes _____ No_____

Please evaluate the applicant's overall clinical performance based upon your knowledge and observation of this individual.

	Unsatisfactory	Adequate	Superior	Unable to Evaluate
Clinical Competence	_______	_______	_______	_______
Professional Judgement	_______	_______	_______	_______
Clinician-Client Relationship	_______	_______	_______	_______
Quality of Record Keeping	_______	_______	_______	_______
Office Appearance	_______	_______	_______	_______
Office Safety/Handicap Access	_______	_______	_______	_______
Psychiatric Emergency/Crisis	_______	_______	_______	_______
Alcohol and Drug Assessment	_______	_______	_______	_______
Child Psychotherapy	_______	_______	_______	_______
Adolescent Psychotherapy	_______	_______	_______	_______
Marital and Family Therapy	_______	_______	_______	_______
Knowledge of Local Resources	_______	_______	_______	_______
Brief Therapy Techniques	_______	_______	_______	_______
Public Speaking/Training	_______	_______	_______	_______
Critical Incident Debriefing	_______	_______	_______	_______
EAP Knowledge	_______	_______	_______	_______
Sexual Harassment Awareness	_______	_______	_______	_______
Violence Prevention Awareness	_______	_______	_______	_______
Legal Resource Awareness	_______	_______	_______	_______
Financial Resource Awareness	_______	_______	_______	_______
Overall Evaluation	_______	_______	_______	_______

Yes____ No____ I recommend this individual. ***(Please explain any unsatisfactory ratings, inability to evaluate or negative comments on a separate page.)***

Signed ____ ____________________
(Reference) Dated