Email completed application to:
Lindaclew@responseworks.com

ResponseWorks, Inc. Group Practice Application (Canada)

ORGANIZATION NAME: _____

Applying to Provide: ☐ **Trauma Response** ☐ ☐

Is Group Practice able to provide services to any location in Canada ☐ **Yes** ☐ **No**
Is Group Practice able to provide services to any location in the US? ☐ **Yes** ☐ **No**

Is Group Practice able to provide international services? ☐ **Yes** ☐ **No**

Directions: Please complete at least one Service Address and Mailing Address section.
If you have more than two service locations, please include this information on a separate sheet or photocopy this page.

Primary Service Address (1):	Service Address (2):
_____ Address	_____ Address
_____ City State/Province Zip	_____ City State/Province Zip
_____ Phone Number Fax Number	_____ Phone Number _____ Fax Number
_____ Emergency Number cell#	_____ Emergency Number cell#
_____ Email address	_____ Email address
Mailing Address:	NAME AND TITLE OF PRIMARY CONTACT:
_____ Address	_____ Name Title
_____ City State/Province Zip	_____ Phone Number
Is this service address accessible by public transportation? ☐ Yes ☐ No	Is this service address accessible by public transportation? ☐ Yes ☐ No

LIABILITY/INSURANCE INFORMATION

Are all members of the group practice covered by a blanket professional liability insurance policy? ☐ Yes ☐ No
(If yes, please include a copy of face sheet with limits, expiration date and covered employees. If unlimited aggregate amount please state this.)

Company name of liability carrier: _____ Limits of liability: Per occurrence: $____ Aggregate: $____ __

ACCREDITATIONS

Has group practice been awarded any accreditations? ☐ Yes ☐ No
(If yes, please include copy of appropriate documentation)

For Coordination of care, please list major Health Plans and Behavioral Managed Care companies with which you participate

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STAFFING INFORMATION
Please indicate names and service locations of professional staff on the enclosed Professional Staff Roster.

AFTER HOURS COVERAGE
Please indicate the method used to provide 24/7 coverage for emergencies: _____

_____

_____ _____

Signature Title Date

ResponseWorks, Inc. Group Member Profile

Instructions: This page is to be completed by each clinician in the group. Please make copies as necessary.

ORGANIZATION NAME: _____

GROUP MEMBER NAME: _____
Last Name First Name MI

LICENSURE/CERTIFICATION and/or ACCREDITATION:
Licensed Discipline:
Please indicate the discipline under which you are Licensed and/or Certified.
Please attach a copy of diploma for highest clinical degree and all current licenses/certifications

☐ Psychologist ☐ Social Worker ☐ CAC ☐ LPC/MHC ☐ MFT/MFCC ☐ Other: _____
specify

Additional Certification:
Please attach a current copy of all additional certifications

☐ CEAP ☐ Chemical Dependency Certification ☐ Trauma Certification

Please indicate specific training you have received in crisis response, traumatic stress and traumatic grief services, including dates and trainer. Please describe your most recent two occasions providing trauma response services, including dates: *(Use other side.)*

MALPRACTICE PROFILE:
Have you ever been the subject of any malpractice action/investigation? ____ Yes ____ No
If yes, please attach explanation.

CLINICAL AND PRACTICE PROFILE:
Specialties *(Please indicate which of the following you provide)*

___ Critical incident debriefing/trauma response services ___ Mass casualty disaster response services ___ Family assistance services ___ Supervisor/management training or consultation ___ Faculty/administration training or consultation ___ Violence in the workplace consultation ___ Alcohol/Substance abuse ___ EMDR ___ Sexual assault/ Rape support ___ Topical seminar/brown bag presentation	___ Brief solution-focused therapy ___ LGBT and Q ___ Anger management ___ Adolescents/young adults ___ Veterans ___ Evening appointments ___ Weekend appointments ___ Suicide/emergency assessments ___ Other: _____

Special Populations and Foreign Languages *(check all that apply)*

___ Hearing Impaired ___ Visually Impaired ___ Speech Impaired ___ Other Disabled	___ Arabic ___ Chinese ___ French ___ German	___ Greek ___ Hebrew ___ Italian ___ Japanese	___ Korean ___ Polish ___ Portuguese ___ Russian	___ Spanish ___ Swedish ___ Vietnamese ___ Other:_____

I attest that all information provided to ResponseWorks, Inc. is true and correct to the best of my knowledge and belief. I agree to notify ResponseWorks, Inc. promptly if there are any material changes in the information provided. I hereby authorize ResponseWorks, Inc. To release information to any person, entity or governmental agency which has a legal right to know under any state or federal law. I agree to hold ResponseWorks, Inc. harmless from any liability for providing any such information as specified herein.

_____ _____
Group Member Signature Date

PROFESSIONAL STAFF ROSTER

Clinician Name Last Name, First Name, Degree, Licensure	**Service Locations**

RESPONSEWORKS, INC.
GROUP PRACTICE APPLICATION CHECKLIST

Please check to ensure the following documents are present and completed before forwarding to ResponseWorks, Inc.

1. Letter of Agreement is executed, unaltered and includes all attachments ___
2. Application is completed, signed and dated ___
3. Copy of current malpractice insurance face sheet ___
4. Copy of any/all facility accreditations ___
5. Group Member Profile is completed by each clinician ___
6. Copy of current professional license for all group members ___
7. Copy of additional certifications for all group members ___
8. Curriculum vitae for all group members ___