REQUEST FOR AFFILIATE CREDENTIALING

Practice Name:_____ Date:_____

Contact Person: _____

Phone: _____Fax:_____ Email_____

Mailing Address:_____

Clinical Address (s):_____

_____

_____

Days/hours of appointment availability:_____

Are your offices handicapped accessible? ____Yes ____No

Does your practice have experience providing EAP services? ____Yes ____No
Does your practice have experience providing substance abuse assessment? ____Yes ____No
Does your practice provide Critical Incident Stress Debriefing? ____Yes ____No
Does your practice include any bilingual clinicians? ____Yes ____No
If so, specify language(s)_____
Does your practice provide federal DOT Substance Abuse Professional evaluations meeting the current federal DOT requirements? ____Yes ____ No
Is your practice interested in providing training services to companies? ____Yes ____ No
If so, what type(s)_____
_____

Mail, fax, or email this request to:
Network Services
Employee & Family Resources
505 Fifth Avenue, Suite 600
Des Moines, IA 50309
Fax (515) 284-5201
affiliate@efr.org

- If EFR has need for providers in your area we will contact you to discuss the credentialing process.
- If EFR does not currently have need for providers in your area, we will add this information to our "Potential Provider" database and contact you when the need does arise.

Thank you for your interest!