CLINICIAN APPLICATION FORM

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS AND RETURN IN THE ENVELOPE PROVIDED OR E-MAIL TO: **amanda.hamments@insteplimited.com**
(Please make sure your contact details are correct)

PERSONAL DETAILS

Full Name: _____ _____ _____ _____
Title | First Name | Middle Name (s) | Surname or Family Name

Home Address (this information will be held in confidence if given): _____

_____

Please indicate where we should address correspondence ☐ Home ☐ Business ☐ Other (Mailing address below)

Home Numbers: Tel: _____ Fax: _____ Mobile: _____

Email: _____

Foreign Languages Spoken: _____

Occasionally clients request a clinician of a particular ethnicity, religion, Iwi affiliation or sexual orientation. Please provide any information you would be happy for Instep to hold on these areas: _____

_____

_____

PROFESSIONAL DETAILS

Your business name (if applicable): _____

Business Address (physical address): _____

_____

Business Numbers: Tel: _____ Fax: _____ Mobile: _____

Email: _____

Type of premises: ☐ Own separate business address ☐ Dedicated room at home ☐ Other (please specify)

Mailing Address (if different): _____

_____

Please describe your premises in the criteria indicated:

Pedestrian/Public transport access: _____

Access by private transport: _____

Waiting area: _____

Access for those with disabilities: _____

Access to toilet/hand washing: _____

Personal security in general area: _____

Privacy/risk of overhearing: _____

Your personal security (in case of abusive client): _____

What are your security arrangements for client records? _____

Would you be happy to travel to meet a client? ☐ Yes ☐ No

Would you be happy to make house calls? ☐ Yes ☐ No

Hours of availability: _____

Please provide **email addresses** of two professional referees including your supervisor where applicable. In the case that your referees do not have email addresses please provide phone numbers.

Referee 1: _____ (Title) _____ (First Name) _____ (Middle Name (s)) _____ (Surname or Family Name)

Email: _____

Address: _____

Contact Numbers: Tel: _____ Fax: _____ Mobile: _____

Please tick here if the above referee provides you with supervision: ☐

Referee 2: _____ (Title) _____ (First Name) _____ (Middle Name (s)) _____ (Surname or Family Name)

Email: _____

Address: _____

Contact Numbers: Tel: _____ Fax: _____ Mobile: _____

Please tick here if the above referee provides you with supervision: ☐

Please describe any ongoing supervision arrangements: _____

_____

Please provide details of one academic referee, if you have graduated in the last five years:

Title	First Name	Middle Name (s)	Surname or Family Name

Address: _____

_____

Contact Numbers: Tel: _____ Fax: _____ Mobile: _____

Email: _____

Please list details of professional qualifications and any accreditations or certification to practice, including relevant dates, training institutions & examining bodies (should you be successful copies of certificates will be required):

Examining Body/Institution	Qualification/Training	Date Attained

PROFESSIONAL ASSOCIATION **(mandatory)**

Name of Professional Association (s) you belong to: _____

_____

_____

Please note if you are only a provisional member.

Are you a member of DAPAANZ? ☐ Yes ☐ No

AREAS OF INTEREST

Areas in which you have experience in working:

- ☐ Abusive Relationships
- ☐ ***** Adolescents/under 18's
- ☐ ***** Alcohol/Substance Abuse
- ☐ * Alcohol/Substance Assessments
- ☐ Anger Management
- ☐ Antisocial Behaviour
- ☐ Anxiety Disorders
- ☐ Career Guidance / Development
- ☐ Child Abuse Victim
- ☐ Child Abuse Perpetrator
- ☐ Chronic Pain
- ☐ Co-dependency
- ☐ Consultation Liaison/ Groups
- ☐ Couples Therapy
- ☐ ***** Critical Incidents
- ☐ Developmental Disorders
- ☐ Disability and Evaluation
- ☐ Disciplinary Stress
- ☐ Eating Disorders
- ☐ Family Court Approved
- ☐ Family Therapy
- ☐ Family/Victim Violence
- ☐ Financial Stress
- ☐ Gambling
- ☐ Gay/Lesbian issues
- ☐ Grief & Loss
- ☐ Interpersonal relationship conflicts
- ☐ Legal Concerns
- ☐ Major Depression
- ☐ Medical Problems
- ☐ Men's issues
- ☐ Mild/Moderate Depression
- ☐ Mood disorders
- ☐ Pain management
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Physically Impaired
- ☐ Redundancy Support
- ☐ Risk of Imminent Harm
- ☐ Schizophrenia
- ☐ Self-Esteem Issues
- ☐ Separation/Divorce
- ☐ Sexual Abuse
- ☐ Sexual Dysfunctions
- ☐ Sleep Disorders
- ☐ Stress Management/Relaxation
- ☐ Terminal Illness
- ☐ Threat of Violence
- ☐ Women's Issues
- ☐ Work-Family Balance
- ☐ Workplace Bullying
- ☐ Others (please list)

_____

_____

_____

_____

*** further details will be required, see page 5-6**

Do you do Professional Supervision? ☐ Yes ☐ No

I would like to be described as a: _____

Please describe your theoretical approach: _____

_____

_____

_____

Please describe any experience, past or current working with EAP's: _____

_____

_____

_____

_____

PROFESSIONAL EXPERIENCE:

Are you qualified to use psychometric testing? ☐ Yes ☐ No

If 'yes', which instruments do you use? _____

_____

_____

Please describe any other training or experience you feel may be relevant: _____

_____

_____

_____

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_____

How many years experience do you have? _____

ALCOHOL & SUBSTANCE ABUSE

Please list details of professional training, including relevant dates & training institutions/trainers

Training Institutions	Qualification/Training	Grade	Date attained

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

Please list your five most recent experiences with CISM

Type of incident	No. of this type	Debrief location	No. of individuals debriefed

Please list details of CISM professional training, including relevant dates & training institutions/trainers

Training Institutions	Qualification/Training	Grade	Date attained

ADOLESCENTS/UNDER 18'S***

Please list details of professional training, including relevant dates & training institutions/trainers (if you wish to work with under 18's this information must be provided)

Training Institutions	Qualification/Training	Grade	Date attained

*****You'll be asked to provide evidence of Police Clearance if you're qualified to work with children and adolescents under 18's.**

INSURANCE INFORMATION **(highly encouraged)**

☐ Do you have Indemnity Insurance?
☐ Do you have Public Liability Insurance?

FURTHER DETAILS

Please respond to the following questions, attaching an explanation and relevant correspondence where you have ticked a 'YES'

- Has your medical or professional license or accreditation ever been revoked, suspended or subject to probation or any conditions or limitations? ☐ Yes ☐ No
- Have you ever voluntarily surrendered your license or authority to practice? ☐ Yes ☐ No
- Have you ever had a complaint filed with your licensing or governing body? ☐ Yes ☐ No
- Has any professional liability insurer or carrier made an out-of-court settlement or paid a judgment or professional liability claim on your behalf in the past 10 years? ☐ Yes ☐ No
- Have you ever been denied professional liability insurance, or has your insurance ever been cancelled or refused renewal? ☐ Yes ☐ No
- Have you ever been the subject of disciplinary proceedings by any professional association? ☐ Yes ☐ No
- Have you ever been convicted of, or pleaded guilty to, a crime? ☐ Yes ☐ No

GST Registered? ☐ Yes ☐ No

Please give us details of your fees (exclusive GST):

$ _____	$ _____	$ _____	$ _____
EAP Counselling Referrals	Couples Counselling	Written Assessments (if required)	Critical Incident Debriefing

I understand that the submission of this information does not constitute approval or acceptance in Instep Limited Clinicians Network and grants me no rights or privileges in the Network until such time as I receive notice of participation.

NB. Sending this form indicates your agreement for us to hold this information on our secure database in both electronic and writing formats.

Signed: _____

Dated: _____