CLINICIAN APPLICATION FORM

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS AND RETURN IN THE ENVELOPE PROVIDED OR PROVIDE THE INFORMATION REQUESTED VIA FAX TO: **04 382 8797**

(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: _____

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 (street 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 are: _____

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 details of two professional referees including your supervisor where applicable:

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

Address: _____

_____

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

Email: _____

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

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

Address: _____

_____

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

Email: _____

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

Name of Professional Association (s) you belong to (please include membership number if applicable) : _____

_____

_____

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
- ☐ Mood disorders
- ☐ Pain management
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Physically Impaired
- ☐ 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**

Any further experience / qualifications you would like Instep to be aware of (attach separate paper if required):

_____

_____

_____

_____

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: _____

* 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

INSURANCE INFORMATION

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

(Should you be successful copies of relevant certificates may be required.)

SPECIFIC SUPERVISION INFORMATION

I am able to provide individual supervision at my business address listed previously: ☐ Yes ☐ No

I am able to provide group supervision if required? ☐ Yes ☐ No

I would consider holding Supervision sessions at an ACC Branch office: ☐ Yes ☐ No

I currently provide treatment services for ACC claimants: ☐ Yes ☐ No

If Yes, please state which type of treatment you provide eg: sensitive claims, head injury, pain management and the % of your caseload it represents. (Please refer to clause 3.3 of your contract & note that your application may be declined accordingly):

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

Specific supervision experience:

Please provide contact details for 2 (two) supervisees whom who have worked with as a supervisor in the past two years and who have agreed to provide a reference for you in this capacity.

Supervisee 1: Name: _____

Contact phone: _____ fax: _____ mobile: _____

Email: _____

Supervisee 2: Name: _____

Contact phone: _____ fax: _____ mobile: _____

Email: _____

DECLARATION OF SUPERVISION

In order to confirm that supervisors are maintaining professional competence, please complete the details below for your own supervisor(s):

Name: _____

Practice address: _____

_____

Phone number: _____

Frequency of supervision received: _____

For the duration of this contract, I will notify instep limited if any change to my supervision situation occurs

Signed: _____ Date: _____

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

Are you GST Registered? ☐ Yes ☐ No

Please give us details of your fees:	$ _____ EAP Counselling Referrals	$ _____ Couples Counselling	$ _____ Supervision Referrals	$ _____ Written Assessments (if required)	$ _____ Critical Incident Debriefing

I understand that the submission of this information does not constitute approval or acceptance in the Instep Limited Clinician 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: _____