

# The Wellness Corporation

Please complete the following information:

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_(     ) \_\_\_\_\_

Fax Number: \_(     ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

## Office Address Information:

Office Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_(     ) \_\_\_\_\_

Professional Degree; Conferring Institutions; and Licensure:

\_\_\_\_\_

Please list Insurance Panels that you maybe on:

\_\_\_\_\_

\_\_\_\_\_

Foreign Language Spoken: \_\_\_\_\_

Years of Post Graduate Direct Clinical Experience: \_\_\_\_\_

Colleague that you would recommend to join The Wellness Corporation panel:

\_\_\_\_\_

\_\_\_\_\_

Briefly Describe Your EAP and/or Substance Abuse Background:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Feel free to fax your resume, copy of you license and copy of your malpractice with this form. This may expedite the application.**

Please send to: Mike Diggins, Network Manager  
800-361-5527 x 122 Fax 508-842-3066  
mdiggins@wellnesscorp.com