AFFILIATE PROVIDER UPDATE FORM

Please include a copy of your license, liability and W9

Name: _____ (First) _____ (Last) _____ (Checks made to)

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Office Phone: (_____)_____ Fax: (_____)_____

Email Address: _____

Practice: ☐ Group ☐ Private

Platform: ☐ In-person ☐ Video ☐ Phone

Tax ID/FEIN: _____

Practice Location: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Specialties: (Check all that apply)

☐ Trauma	☐ Abuse	☐ ADD/ADHD	☐ Play Therapy
☐ Addiction	☐ Gambling	☐ Grief/Loss	☐ PTSD
☐ Child	☐ Adolescent	☐ EMDR	☐ Eating Disorder
☐ Financial/Budget	☐ Anger	☐ Christian/Faith	☐ EMDR
☐ Anxiety/Depression	☐ Adoption	☐ Fertility	☐ First Responder
☐ Marital/Couples	☐ LGBTQ	☐ Sexual Disorder	☐ Sleep Disorder

Age Range: _____ to _____

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