

## EAP AFFILIATE COUNSELOR ETHICS AFFIRMATION QUESTIONS

*This document shall be completed for each provider under the EAP Affiliate Agreement with LifeSpring Health Systems and a copy of the completed form shall be sent to LifeSpring within 30 days via fax - 812-771-6900, e-mail – eap@lifespringhealthsystems.org, or US mail – LifeSpring Health Systems, ATTN: EAP, P. O. Box 769, Jasper, IN 47547-0769. With questions, call 812-482-3020.*

Printed Name of Provider \_\_\_\_\_ License Title \_\_\_\_\_

Degree \_\_\_\_\_

Name of EAP Affiliate Company \_\_\_\_\_

Please answer the following questions by checking the appropriate box:

1.	Has your employment ever been involuntarily terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Has your license to practice in any jurisdiction ever been denied, restricted, suspended, reduced, not renewed, or placed on probation by a licensing agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has your employment or clinical privileges ever been suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever voluntarily relinquished your employment or professional license to practice as an alternative to disciplinary action or during an investigation into your employment conduct or professional competence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever resigned, been suspended, or excluded from the staff of any hospital or professional organization because of problems regarding loss or limitations of privileges or disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you or your employer (past or present) ever been suspended or excluded from recovering payment under Medicare or Medicaid programs for services you provided or supervised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you had a relationship with a client or former client that was sexual in nature or otherwise in violation of any agency rules or ethical rules of your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Has any professional organization, regulatory board, or hospital declared any actions by you to be unethical or are you currently under investigation for any actions of unethical conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Do you have any misdemeanor or felony charges pending or have you been convicted of a misdemeanor or felony other than a minor traffic violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever had professional liability (malpractice) claim(s) brought and/or sustained against you or against your employer (past or present) related to your actions?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any "Yes" answers on the back of this sheet.

*I certify that the answers given by me to the foregoing questions are true and correct. I understand that misrepresentation of information on this form may be cause for termination if I am hired. Permission is hereby given to investigate any responses which would raise questions in regards to my professional integrity.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Printed Name