Holman Family Services

469-844-5437

First Name:	Middle	Last Name:
License Name:	License #	State issued:
NPI #	Tax ID#	SSN:
Date of birth:	H-Phone:	M-Phone:
Current address:		
City:	State:	ZIP Code:
Previous address:		
City:	State:	ZIP Code:

EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		How long?
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Position:		

EMPLOYMENT INFORMATION #2		
Previous employer:		
Address:		How long?
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Position:		

EMPLOYMENT INFORMATION #3		
Previous employer:		
Employer address:		How long?
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Position:		

EMPLOYMENT INFORMATION #4		
Previous employer:		
Address:		
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Position:		

REFRENCES		
Reference Name:		
E-Mail Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

Reference Name:		
E-Mail Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
Reference Name:		
E-Mail Address:		Phone:
City:	State:	Zip Code:
Relationship:		
Reference Name:		
E-Mail Address:		Phone:
City:	State:	Zip Code:
Relationship:		

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is your Counseling Theory and why?

Why did you choose your profession?

What would you do if someone were suicidal or homicidal?

If any, Please list the Insurance Companies you are a provider with:

Do you currently or have you ever in the past received a reprimand on your license? If yes, please explain

Please provide your school Supervisors name or your LPC-S supervisors name and their full contact info:

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Why do you want to complete your hours with Holman Family Services?

Please provide the name of your Liability Insurance, policy number and full contact information. Holman Family Services requires that each clinical staff person, practicum student and intern carry their own liability insurance with a minimum of a 1 million dollar coverage.

Please use the space below to share any other info that would assist us in deciding rather you are the best candidate for HFS?

I certify that all the information that I have provided is true and correct. I authorize Holman Family Counseling, LLC. to verify all the information provided in this form.

Printed Name:	Date:
Signature	Date:

Please Scan or Save and e-mail document to info@HolmanFamilyServices.com