LINK-KID AFFILIATE PROVIDER INFORMATION FORM

Provider First Name: _____

Provider Last Name: _____

Email Address: _____

Main Phone Number: _____

Mailing Address: _____

Street Address: _____

I am working in Private Practice: ☐ I am working for an Organization: ☐

If yes to organization, which organization: _____

Insurances Accepted:

Which EBT treatment(s) do you provide?:

Training Details (Please provide information on the dates and trainer of each EBT you are trained in. Please also indicate if you participated in a consultation process following the EBT.)

Please email completed form to cttcreferral@umassmed.edu