EAP Client Registration Form

All information you provide is strictly confidential

Employee Organization: ______________________________

Client Information

Name: ____ Date of Birth: _______________________________

If under 18 yrs., legal guardian name: ____

Relationship to Employee: Self Family Member

Home Address: ____

Preferred Phone Number: _______________________________ Cell Work Home

Emergency Contact Name and Phone Number: ____

Pronouns: ______________________________________

Position Title: ____

UR Employee Information
(**DO NOT complete if you are not employed by UR**)

Work Status: FT PT Temp Per Diem Volunteer Resident/Fellow

Work Location: River Campus Tech Park URMC UR Other Union Member: Yes No

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Have you or a member of your family used EAP services in the past? Yes No

Is your reason for seeking EAP services work related? Yes No

Was your call to EAP answered promptly? No Yes, immediately Yes, within an 8-hour timeframe

Was your appointment scheduled in a timely manner? Yes, within 3-5 days
I opted for more than 5 days No appointment was available within 5 days

Ethnicity: American Indian/Alaskan Native Asian Black/African American Caucasian/White
Hispanic/Latino Native Hawaiian/Other Pacific Islander Multi Racial Other

Marital Status: Married Single Divorced Separated Partnered Widowed

*If attending session, spouse/partners' name (see *attached addendum*)

If under 18 yrs., legal guardian name: ____

Do you have a disability that you would like us to be aware of? Yes No

How many alcoholic beverages do you consume each week? ____

Do you use recreational drugs or substances? Yes No

Are you currently on any medications? ____

Are you a veteran? Yes No

Is anyone currently making you feel unsafe in any way? Yes No

Briefly explain why are you seeking EAP services :

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Please list any symptoms you have experienced over the past 1-4 weeks:

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