



# Contract Clinician Application

For Online Applications: Please attach your resume as part of your application and email to Stephanie Haen at [shaen@familycenters.org](mailto:shaen@familycenters.org)

Theories/Approaches you use:

For Other Applications: Please include a printed copy of this application with your resume and mail to:

**Stephanie Haen**  
**Director of Behavioral Health**  
**Family Centers**  
**20 Bridge Street**  
**Greenwich, CT 06830.**

Please list your areas of specialization:

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Professional Credentials:

Degree \_\_\_\_\_ License \_\_\_\_\_

Are you fluent in any languages other than English?

\_\_\_\_\_

Do you have a private practice and if so, where?

\_\_\_\_\_

Work Schedule Availability:

Please note one or more evenings per week are required. General hours are Monday - Thursday, 9 am - 9 pm and Friday, 9 am - 5 pm. Saturday by appointment.

Days

Hours

- Monday \_\_\_\_\_
- Tuesday \_\_\_\_\_
- Wednesday \_\_\_\_\_
- Thursday \_\_\_\_\_
- Friday \_\_\_\_\_
- Saturday \_\_\_\_\_

Work Location Availability:

Stamford  Greenwich  Darien

Which of the following modalities/populations do you feel competent working with?

**Modalities**

**Populations**

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Child (youngest age ____) | <input type="checkbox"/> OCD                 |
| <input type="checkbox"/> Families   | <input type="checkbox"/> Adult                     | <input type="checkbox"/> Dual Diagnosis      |
| <input type="checkbox"/> Couples    | <input type="checkbox"/> Geriatric                 | <input type="checkbox"/> Conflict Resolution |
| <input type="checkbox"/> Groups     | <input type="checkbox"/> Immigrants                | <input type="checkbox"/> Grief and Loss      |
|                                     | <input type="checkbox"/> LGBTQ                     | <input type="checkbox"/> Self-Harm           |
|                                     | <input type="checkbox"/> Adoptees                  | <input type="checkbox"/> Trauma              |
|                                     | <input type="checkbox"/> Eating Disorders          | <input type="checkbox"/> Phobias             |

Please list interventions you have experience with:

What experience do you have facilitating groups?

Please list three references with contact information:

- 1.
- 2.
- 3.