AUTHORIZATION TO EXTEND EAP SERVICES

(Beyond 12 sessions)

Case number: ☐ Date: ☐

Admission Status *(check one)*: Employee ☐ Family Member ☐ TFO ☐

Presenting Concern:

Goals for Resolution (include progress to date and difficulties encountered):

Rationale for Extension Request:

Requested number of extended sessions (max. six per request): ☐

Clinician: ☐ ☐

(Type or Print Name) (Clinician Signature)

EAP Administrator: ☐ *Number of Sessions Approved:* ☐

Date: ☐

☐ *Approved* ☐ *Denied*