Service Provider Qualification Form

Please complete, sign, and return to the Sandra J. Wing Healing Therapies Foundation by email at info@healingtherapiesfoundation.org or by mail at 5890 Stoneridge Dr., Ste. 104, Pleasanton, CA 94588. Thank you for your interest!

1. Contact Information

Service Provider Legal First Name: _____

Service Provider Legal Last Name: _____

Business Name: _____

Business Address: _____

Business City/State/ZIP Code: _____

Business Phone Number: _____

Business Fax Number: _____

Business Email Address: _____

Business Website: _____

Business License Number: _____

Mailing Address (if different from above): _____

Mailing Address City/State/ZIP Code: _____

I am: _____ Business Owner _____ Employee

Sandra J. Wing Healing Therapies Foundation
5890 Stoneridge Dr., Ste. 104, Pleasanton, CA 94588
Website: www.healingtherapiesfoundation.org
Phone: 925-249-6771

2. Provider Information

Please submit the following documents along with your application:

A. Copies of license, certification, and/or diploma.
B. Certificate of Professional Liability Insurance with coverage limit no less than $1,000,000 per occurrence.
   a. Professional Liability Company Name: _____
   b. Insurance Expiration Date: _____
C. Completed W-9 Federal Tax Form, found at: www.irs.gov/pub/irs-pdf/fw9.pdf

Tell us about the services you provide (check all that apply):

_____ Acupuncture
CA State License Number (required): _____ Expiration Date: _____
Years of Experience*: _____

_____ Acupressure
CA State License Number (required): _____ Expiration Date: _____
Years of Experience*: _____

_____ Therapeutic Massage Check one: _____ CMT _____ CMP
CAMTC Certificate Number (required): _____ Expiration Date: _____
Years of Experience*: _____

_____ Guided/Visual Imagery
License/Certificate Number: _____ Years of Experience*: _____

_____ Deep Breathing Meditation
License/Certificate Number: _____ Years of Experience*: _____

Please answer the following questions:

A. Are you trained to work with oncology patients? _____ Yes _____ No
B. Please state your training/certification as you would like it to appear on our website:

   _____

C. We strongly encourage our service providers to receive an annual flu shot, as services are being rendered to patients with compromised immune systems. Do you receive an annual flu shot?
   _____ Yes _____ No

*Three years minimum experience required.

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3. Sandra J. Wing Healing Therapies Foundation Commitment and Service Rates

All service providers must accept VISA® credit and debit cards.
What is your merchant name? _____
What is your merchant category code (MCC)? _____

Please list your services, rates, and hours (to appear on our website):

Primary Service Type: _____
Standard Rate: $_____/hr or $_____/_____min
Reduced Rate for SJWHTF Beneficiaries: $_____/hr or $_____/_____min

Additional Service Type: _____
Standard Rate: $_____/hr or $_____/_____min
Reduced Rate for SJWHTF Beneficiaries: $_____/hr or $_____/_____min

Business Hours: _____

Are you willing to provide in-home services if requested? _____ Yes _____ No
If yes, in which cities? _____

Are you willing to provide *on-call* in-home services if requested? _____ Yes _____ No
If yes, in which cities? _____

4. Agreement and Signature

By signing below, I certify that the information submitted in this application is true and complete and that I have read and agree to the Sandra J. Wing Healing Therapies Foundation Service Provider Instructions online on the Resources > Providers page at www.healingtherapiesfoundation.org.

Signature: _____ Date: _____

Printed Name: _____

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