HEALTH AND HUMAN SERVICES GROUP
23392 Madero Road, Suite L
Mission Viejo, California 92691
(800) 275-7460; FAX (949) 855-7575

PLEASE PRINT CLEARLY

DEA-EAP: CONSULTATION SERVICE RECEIPT

Authorization Number _____ Clinician's Name: _____

Division: _____ SAC:_____ASAC:_____RAC:_____

Address: _____

Date(s) of Consultation: **Type of Consultation:**

_____ **□ Management □ Organizational □ Crisis Intervention**

Actual Case Problem/Situation Focus:

_____

_____

_____

_____

_____

_____

Actions Taken – Methods Employed:

_____

_____

_____

_____

_____

_____

Results Achieved:

_____

_____

_____

_____

_____

_____

# of Managers Involved: _____ # Employees Involved: _____

Costs: Please attach receipts

Actual Hours Required:_____ Actual Travel Time:_____ Travel Costs:_____

Manager's Name: _____ _____
Printed **Signature**

Approval: _____ Date: _____
Nels Klyver, Ph.D. Administrative Clinician

<u>Please make copies as needed</u> – FORM # 14