

**Appendix 4. Critical Incident Stress Management Counselor Session Form**

**STATE OF MARYLAND (SOM), EMPLOYEE ASSISTANCE PROGRAM (EAP)  
CRITICAL INCIDENT STRESS MANAGEMENT (CISM)  
COUNSELOR SESSION ATTENDANCE FORM**

The intent of this form is to obtain certification that the contractor provided CISM services to the requesting agency promptly at the scheduled start time and continued said services throughout the pre-authorized duration.

**COMPLETE STEP BELOW PRIOR TO SESSION START**

The EAP Contractor completes sections I and II (electronically); submits to the applicable Agency EAP Representative.

**COMPLETE STEPS BELOW AFTER SESSION END**

The EAP Agency Representative reviews sections I – II, completes section III and returns to EAP Counselor;

The EAP Counselor will forward form to the EAP Contractor; and

The EAP Contractor will forward a copy of this form to the State's Contract Manager, Employee Relations Division, and EAP Coordinator.

**Section I and II: Completed by EAP Contractor ONLY**

**SECTION I: AGENCY INFORMATION**

**Session Date:** \_\_\_\_\_ **Scheduled Session Time:** \_\_\_\_\_ **AM/PM** **Authorized Hour(s):** \_\_\_\_\_

**Requesting Agency:** \_\_\_\_\_

**Location of Services:** \_\_\_\_\_ **County:** \_\_\_\_\_  
(Address, City, State, Zip Code)

**SECTION II: AGENCY EAP REPRESENTATIVE INFORMATION**

**Name:** \_\_\_\_\_  
(First and Last Name)

**Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Section III: Completed by Agency EAP Representative ONLY**

**SECTION III: EAP COUNSELOR INFORMATION**

**Counselor's Name:** \_\_\_\_\_  
(First and Last Name)

**Session Start Time:** \_\_\_\_\_ **AM/PM** (Circle one) **Session Complete Time:** \_\_\_\_\_ **AM/PM** (Circle One)

\_\_\_\_\_  
**Agency EAP Representative (Print Name)**

\_\_\_\_\_  
**Agency EAP Representative (Signature)**