 

**P.O. Box 45180 Salt Lake City, UT 84151-0180**

[Behavioral Health Provider's Name] with [Provider's Clinic/Hospital Name] [Address] [City, State, Zip Code]

Subject: Affidavit Regarding Eye Movement Desensitization and Reprocessing (EMDR) Training and Treatment

University of Utah Health Plans has established a new clinical practice guidelines regarding Eye Movement Desensitization and Reprocessing (EMDR). Copies of policies may be found online at https://admin.uhealthplan.utah.edu/medicalpolicy/updatedpolicy. In order to list [Behavioral Health Provider's Name] in one or more of our provider directories as an EMDR provider, we need the attached affidavit completed by the practitioner and returned with your provider application or emailed to providercontracting@hsc.utah.edu or by fax to 801-281-6121 within 30 days of this letter being received. Failure to complete and return this affidavit will result in us removing EMDR as an area of interest in your provider directory profile.

=====================================================================================

I am [Behavioral Health Provider's Name] with [Provider's Clinic/Hospital Name] [Address] [City, State, Zip Code], do solemnly declare and affirm that:

1. I am a practitioner who specializes in Eye Movement Desensitization and Reprocessing (EMDR), and I wish to declare this an area of interest in health plan directories.
2. I have undergone appropriate training in EMDR and possess the necessary qualifications to administer this therapeutic modality.
3. I completed my initial training of 50 hours with an approved EMDRIA training program on this date \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_.

Please attach certificates or check not applicable 🗆

1. I have completed 12 hours of additional training with an approved EMDRIA training program and recertified on this date \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Please attach certificates or check not applicable 🗆

1. I have treated (insert approximate number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ patients in the past 12 months using the EMDR procedure.
2. I attest that I adhere to the ethical and professional standards required for the practice of EMDR therapy.
3. I am aware that providing false information in this affidavit may result in legal consequences.
4. I declare under penalty of perjury that the foregoing is true and correct.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**