Alabama Veterinary Professionals Wellness Program

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Assistance Agreement

Chemical Dependence

The Alabama Veterinary Professionals Wellness Program, WELLNESS PROGRAM, is sponsored by the Alabama Veterinary Medical Association, ALVMA and the Board of Veterinary Medical Examiners. The Alabama Veterinary Professionals Wellness Committee, AVPWC, appointed by the Board of Veterinary Medical Examiners oversees and directs the program. The purpose of the WELLNESS PROGRAM is "to provide a supportive program to Licensed Veterinary Professionals, and their families by assisting the professional with remedial health problems that cause impairment, and to protect the public, by promoting early identification of problems and intervention, overseeing evaluation and rehabilitation, and monitoring to provide documentation of well-being for the professional." The purpose of this agreement is to establish a program to objectively document successful recovery, to detect relapse early, should it occur, and to promote accountability to improve outcomes.

Last Name:________________ First Name:_______________ DOB:_________ SSN: ____________

Addresses

Home:____
Street Address City State Zip

Office:____
Street Address City State Zip

Other: ( ) ____
Street Address City State Zip

Other: ( ) ____
Street Address City State Zip

Phones, etc.

Home Phone: ( )___________ Office Phone: ( )___________ Beeper: ( )_________

Mobile Phone: ( )___________ Fax: ( )___________ Other ( ): ( )_________

Email Address: _____________________________ Date: ______________________

*(Please place an asterisks beside preferred telephone number. Mail will be sent to your home address marked "Confidential and Personal" unless otherwise indicated by you.)

Significant other or emergency contact: Name:______________________ PHONE:________________

Term of Agreement

1. I, ______________________________, DVM or LVMT agree to the terms of this agreement for a **period of five (5) years** from the date of this agreement. Alterations cannot be made without prior approval from the program director. Failure to adhere to the terms of this agreement may result in a report being made to the Alabama Board of Veterinary Medical Examiners. ______(Initials)

Toxicology Testing

2. I agree to **abstain** from any and all mood-altering chemicals (including but not limited to alcohol, marijuana, tranquilizers, sedatives, stimulants, narcotics, ultram (tramadol), nubain, antidepressants, and soporifics, androgenic steroids, scheduled and/or unscheduled drugs, mood altering over-the-counter medications, etc.) except as prescribed by my physician and only after consultation with the WELLNESS PROGRAM. I also agree that I will not consume poppy seeds and I will not consume ethyl alcohol in any form (alcohol "free" wine or beer, mouthwash, cough syrup, in food, communion wine or in any other form). If any mood altering and/or potentially addictive medications are required I will notify the WELLNESS PROGRAM, in advance if possible, and provide documentation of the need for the medication (i.e. copy of the prescription or note from the prescribing physician) within 3 days. If the need for the medication is ongoing, I will renew verification every 90 days. ______(Initials)

3. I will submit to **toxicology screening** of urine/blood/sputum/hair (usually urine) as requested. These screening tests will be random and observed. Either the WELLNESS PROGRAM or my Physician monitor, with or without cause, may request additional tests. I will participate in random testing at least 3-5 times per month for six months and 11-13 per year thereafter for the duration of this agreement. I agree to adhere to the urine testing notification and collection procedures and protocols. I agree to check in online or call the 800 number provided on a daily basis, Mon – Fri, as directed. I understand my compliance with checking in online or calling the 800 number is monitored and that if I fail to do this on a given day that an additional test date will be added for each day I fail to check in or call. I further understand that if the notification system fails or I do not receive notification to provide screening tests, within a reasonable period (e.g. approximately 3 times my usual testing frequency) it is my responsibility to notify the WELLNESS PROGRAM. I also agree that it is my responsibility to assure that lab personnel observe all urine specimen collections. If urine specimen collection is not observed the results are invalid. I further understand that if I do not provide a specimen on the day of notification it will be considered a **positive** screen and I may be required to undergo further evaluation . ______(Initials)

4. I agree neither to prescribe mood-altering chemicals to my family nor to keep samples of scheduled medications in my home. ______(Initials)

Primary Care Physician and Medical Treatment

5. I will secure a **primary care physician** to treat my medical problems and I give him/her authorization to communicate directly with the WELLNESS PROGRAM regarding my progress and/or regarding any relevant issues regarding my recovery and their medical care. I agree to release a copy of this agreement to be sent by the WELLNESS PROGRAM to my primary physician with a letter explaining the WELLNESS PROGRAM and my participation. My physician will be:
   ______________________________________ M.D., Phone______________________________
   Street ____City__________________________ Zip________
   ______(Initials)

6. I will not treat myself but will contact my **primary physician** regarding any significant health related issue.
   ______(Initials)

Physician Monitor and the **WELLNESS PROGRAM Reports**

7. I understand that a recovery **monitor**, specifically appointed to serve as a liaison between myself and the WELLNESS PROGRAM is also appointed to assist me. I acknowledge my monitor to be: ___________________
   Street____ City_______________________________
   Zip_________ Phone ___________________________________. ______(Initials)

8. I will meet with my **monitor** on a quarterly basis or more often, if needed, to discuss my progress. I will provide to my monitor at each quarterly visit a list of all 12-step meetings I've attended with dates and locations, and all Caduceus meetings attended. I will also complete a self-assessment questionnaire and provide this to my monitor at the time of my quarterly visit. You may obtain additional "self-assessment" questionnaires from the WELLNESS PROGRAM office. I understand that my monitor is an unpaid volunteer, familiar with recovery and the WELLNESS PROGRAM policies, and that it is my responsibility to assure that monitoring reports are sent and received by the WELLNESS PROGRAM. I understand that more frequent meetings with my monitor, increased frequency of urine testing, and/or further evaluation may be necessary if reports are not received promptly. _____(Initials)

9. I agree to have a worksite monitor ______________________________ Phone Number ___________________. I will ask my worksite monitor to write a brief note to APHP at least quarterly to verify my wellbeing. The note should include: 1. How often and how we are associated. 2. Appearance at work? And 3. Any perceived problems, incident reports, or other concerns. Criteria for worksite monitor: 1) Frequent contact w/our veterinary-participant, 2) Preferably in the same general field, 3) A neutral party (not a partner, political enemy, golfing buddy, etc), 4) Sensitive to confidentiality, 5) Must be approved by: A) The hospital, B) The veterinary-participant, & C) WELLNESS PROGRAM.

Therapeutic Monitoring Group

10. I agree to attend an assigned **Therapeutic Monitored Group, TMG**, meeting weekly for at least 24 months with a facilitator authorized by the WELLNESS PROGRAM. I agree to permit my facilitator ____________ ____________________________, telephone __________________ to provide reports of my progress and to notify the WELLNESS PROGRAM immediately if I fail to satisfactorily advance in my recovery efforts. I agree to release a copy of my treatment records and a copy of this assistance agreement which will be provided by the WELLNESS PROGRAM to my TMG therapist. I will be responsible for all costs incurred with the TMG process (weekly therapy fees charged by the therapist). At the end of 24 months, I agree to abide by the facilitator's recommendations as to additional attendance at these meetings if warranted. ______ (Initials)

Caduceus Meetings

11. I will attend a weekly **Caduceus** group (Health Professionals support group). Location and contact information regarding Caduceus groups are available through the WELLNESS PROGRAM or at www.alvetwellness.com ______ (Initials)

AA and IDAA

12. I will attend AA meetings daily for 90 days, and subsequently at least three **AA or NA** meetings per week. (Caduceus group meetings and aftercare groups may be counted as an AA meeting; however, I will always, throughout this agreement, attend at least one AA or NA meeting per week even if counting these other meetings.) ______(Initials)

13. I will secure an **AA/NA** sponsor and make regular (at least weekly) contact. ______(Initials)

14. I understand that it is important for my family to attend Al-Anon, Alateen, or other support groups, and authorize them to communicate directly with the WELLNESS PROGRAM as needed. ______ (Initials)

General

15. I agree to notify the WELLNESS PROGRAM of changes in my work or home address or telephone number. ______(Initials)

16. I understand that if I fail to meet the conditions of this agreement, I may lose the support of the WELLNESS PROGRAM. In case of relapse I agree to abide by the recommendation for corrective action. Relapse and/or failure to meet conditions may require reporting to the Board of Veterinary Medical Examiners. ______(Initials)

17. I am aware that the members of the Alabama Veterinary Professionals Wellbeing Committee, AVPWC, the committee appointed by the Board of Veterinary Medical Examiners to oversee the WELLNESS PROGRAM, or the staff of the WELLNESS PROGRAM may make inquiries to and receive information from any clinic, veterinary group, or veterinary hospital at which I work, and any staff with whom I associate, members of my immediate family, and my employer concerning any and all aspects of my compliance with the provisions of this Assistance Agreement. I agree to execute an authorization for release of information to the WELLNESS PROGRAM authorizing any physicians or other treatment agents whom I have consulted for care and treatment to release all information concerning my mental and physical health to the AVPWC. I agree to make full disclosure to physicians with whom I share office practice, or call schedule, so that they may be alert to signs of relapse. ______ (Initials)

Release of Information

18. During the course of this agreement, I give my permission for the WELLNESS PROGRAM, when requested, to provide information concerning my recovery status to: (Initial all that apply)

    a. **The Alabama Board of Veterinary Medical Examiners, ABVME**. (Normally the ABVME does not need to become involved with these issues, however, if requested by the Board I give permission for the WELLNESS PROGRAM to provide information to the ABVME regarding my recovery, including a copy of this agreement, treatment records, and other information.)

    b. S**taff or veterinarians in my office**: (List any other individual or organization with which you may need our support.)

    ____
    ____

    _____(Initials)

19. I hereby release and hold harmless the WELLNESS PROGRAM and any and all of its agents, servants, employees or consultants from any claims whatsoever arising out of actions taken by the WELLNESS PROGRAM in good faith in furtherance of the objectives of this Assistance Agreement or the wellness program. ______(Initials)

20. Inherent in this contractual agreement is a requirement of the participant to be appropriately cooperative and courteous to the WELLNESS PROGRAM staff and to pay fees promptly (to the WELLNESS PROGRAM, for urine testing, therapists, etc). ______(Initials)

21. In the event it becomes necessary for the WELLNESS PROGRAM to render a report to the State Board of Veterinary Medical Examiners pursuant to state laws, I authorize the release of any records in the possession of the WELLNESS PROGRAM which relate to my participation including but not limited to records of evaluations and/or treatment for alcohol and drug abuse protected under the provisions of Title 42 USCA Section 290dd-3 and 42 CFR Section 2.1 et sec. I understand that this authorization and release permits the State Board of Veterinary Medical Examiners to receive and examine the records described herein and, if deemed necessary by the Board, to utilize such records in an administrative proceeding instituted by the Board.
    (Initials)

22. Other requirements: (Include psychotherapy, individual counseling, other treatment, etc., if recommended):

______(Initials)

Additional Information

Sex: M or F   Marital Status: ___________ Religious   Preference: _______________ Race: __________
Name of Spouse: ___________________________
List All Substances abused: Place Asterisk by Drug(s) of Choice: ____________ ____________ _________
____________ ____________ ____________ ____________ ____________ ____________ ____________
____________ ____________ ____________ ____________ ____________ ____________ ____________

Psychiatric Comorbidity: (Dual Diagnoses): ________________________ _________________________

We welcome you as a WELLNESS PROGRAM participant.

____
Signature   Date

____
Printed name

____
WELLNESS PROGRAM   Date

____
Printed name