Alabama Veterinary Professionals Wellness Program

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Assistance Agreement

The Alabama Veterinary Professionals Wellness Program, AVPWP, is sponsored by the Veterinary Medical Association, VMA, and the Alabama State Board of Veterinary Medical Examiners and is directly supervised by the Alabama Veterinary Professionals Wellness Committee, AVPWC. The AVPWP can assist veterinary professionals by documenting their health and compliance with recommendations. The undersigned veterinary professional agrees there has been a problem with stress, adjustment, behavior, and/or mental illness (such as depression, anxiety, or other). The purpose of this agreement is to provide a mechanism to document compliance with treatment recommendations.

Last Name:_____ First Name:_____ DOB:_____ SSS: _____

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

Home Phone: (___)_____ Office Phone: (___)_____ Beeper: (___)_____

Mobile Phone: (___)_____ Fax: (___)_____ Other ( ): (___)_____

Email Address: _____ Date: _____

*(Place asterisks beside preferred telephone number. Mail will be sent to your home address marked “Confidential and Personal.”)

Significant other or emergency contact: Name:_____ PHONE:_____

1. I, _____, DVM agree to the terms of this agreement for a period of 5 years from the date of this agreement. This agreement may be extended if warranted. Alterations in this agreement cannot be made without prior approval from the program director.
   _____(Initials)

2. I will secure a primary care physician to treat my medical problems and give him/her authorization to communicate directly with my psychiatrist, psychologist, counselor, and/or AVPWP on my progress. This physician will be _____MD, Phone_____
   Street _____City_____ Zip_____
   _____(Initials)

3. I will not treat myself for any illness but will contact one of my physicians as appropriate.
   _____(Initials)

4. I agree to obtain counseling and/or treatment from _____ located at _____, home telephone #_____, and office telephone #_____, and if deemed necessary by AVPWP staff to provide free and unlimited release of all information concerning my health and participation in treatment to the AVPWP Director and staff. I understand the need for and have requested that my treating clinician, named above, notify AVPWP immediately of: A) failure to progress in treatment; B) any change of medication; C) discontinuation of therapy; D) change of treating professional; E) failure to appear for appointments, continue prescribed medications, or cooperate in the therapeutic process. _____(Initials)

5. I agree to obtain Psychiatric treatment and F/U from _____ located at _____, home telephone #_____, and office telephone #_____, and if deemed necessary by AVPWP staff to provide free and unlimited release of all information concerning my health and participation in treatment to the AVPWP Director and staff. I understand the need for and have requested that my treating clinician, named above, notify AVPWP immediately of: A) failure to progress in treatment; B) any change of medication; C) discontinuation of therapy; D) change of treating professional; E) failure to appear for appointments, continue prescribed medications, or cooperate in the therapeutic process. _____(Initials)

6. I agree to request a letter from my treating clinician(s) (as in item #4 and 5 above) to AVPWP indicating continued participation and continued progress in treatment. This letter must be received by AVPWP on a quarterly basis. Supplying this letter is essential to continued assistance by AVPWP and is my responsibility. I agree to notify the AVPWP of any changes in physical or mental health, address or employment. _____(Initials)

7. Although substance abuse is not a problem in my situation I understand that it may be beneficial to me at some point in time to document, if there are any concerns, that I am not taking any other drugs other than prescribed. Therefore, I agree, if requested, to submit to urine/blood/sputum/hair or other screening tests. Testing, if requested, must be performed within 24 hours of request at a specified laboratory. Specific instructions will be given if necessary. _____(Initials)

8. I understand that if I fail to meet the conditions of this agreement, I may loose the support of the AVPWP. In case of unauthorized use of controlled substances I agree to withdraw from practice immediately and enter evaluation and/or treatment. _____(Initials)

9. I authorize the AVPWP to receive information from any hospital or clinic at which I hold privileges, and any veterinary professionals or non-veterinary professionals with whom I associate in the practice of veterinary medicine, 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 AVPWP authorizing any veterinary professionals or other treatment agents whom I have consulted for care and treatment to release all information concerning my mental and physical health. _____ (Initials)

10. Agencies or organizations that may care about my health and well-being are listed below. During the duration of this AVPWP agreement, I understand that when requested, information concerning my status will be given by AVPWP to (Please initial any that apply. If unsure just leave blank.):

_____ (Initials) a. The Alabama State Board of Veterinary Medical Examiners

_____ (Initials) b. My malpractice insurance carrier:

_____

_____

_____ (Initials) c. Other veterinary professional/medical groups who may need reports:

_____

_____

11. I agree to report my status to hospitals or groups where I have privileges, and to allow the AVPWP to send progress reports to designated persons at these hospitals or groups when requested. These designated individual(s) are _____and_____. _____(Initials)

12. I understand that the AVPWP program is not responsible for insuring compliance to restrictions or probationary orders issued by the Board or other state or federal regulatory agencies (if any). _____(Initials)

13. I understand that the AVPWP program assumes no responsibility for verification of my qualifications, background or history except as it relates to my participation in the program. _____ (Initials)

14. I hereby release and hold harmless the AVPWP and any and all agents, servants, employees or consultants of the Medical Association of the State of Alabama or the AVPWC from any claims whatsoever arising out of actions taken by AVPWP in good faith without malice in furtherance of the objectives of this Assistance Agreement. _____(Initials)

15. Inherent in this contractual agreement is a requirement of the participant to be appropriately cooperative and courteous to the AVPWP staff and pay all appropriate fees in a timely manner. (The fee for AVPWP participation is $15 per month for VMA members and $25 per month for non-members.) _____(Initials)

16. I agree to notify AVPWP of any change of address or phone number. _____ (Initials)

Additional Information

Sex: M or F Marital Status: _____ Religious Preference: _____ Race: _____

Name of Spouse: _____

VMA Member: Y or N **Malpractice Carrier**: _____

Alabama License Status: Active Inactive Out of State Retired Unlicensed

Vet School Attended: _____ Grad Yr _____

Residency: Specialty: _____ Training Program: _____ Grad Yr _____

Residency: Specialty: _____ Training Program: _____ Grad Yr _____

Residency: Specialty: _____ Training Program: _____ Grad Yr _____

List all States where you have a Vet License: ____ ____ ____ ____ ____ ____ ____ ____

17. Other requirements:

_____(Initials)

Witness

Participants Signature Date

AVPWP

Date

cc: Psychiatrist
Therapist
Primary Veterinary professional