

ATTUD TREATMENT PROGRAM WEBSITE LISTING: APPLICATION FORM

This form is intended to provide a mechanism by which treatment providers and programs can apply to list their services on the ATTUD web site (www.attud.org). Those seeking treatment resources will be able to review the listed treatment programs for suitability.

Please complete the following form describing your Tobacco Dependence Treatment Program. Please answer all questions, providing detailed information (the table will expand to accommodate your responses). Please **do not** send any supplemental materials unless this is specifically requested.

The ATTUD Review Panel will evaluate submissions to determine if all categories have been answered and whether any clarifications are required. Applications will be denied for the following reasons:

1. Gross misrepresentation, false, or misleading claims of the program and its treatment protocols.
2. Primary or substantial use of non-evidence based treatment components.
3. Relationship (financial or otherwise) with the tobacco industry.

If the submission meets ATTUD's standards for listing, the program contact will be so notified. Your program's description will be provided as a viewable and / or downloadable PDF file from ATTUD's website.

Inclusion on this list does not imply endorsement by ATTUD. ATTUD reserves the right to exclude programs based on the criteria stated above. A review panel appointed by the ATTUD Board of Directors will perform these reviews. If you have questions, feel to contact the ATTUD Communications Chairperson (contact information can be found at www.attud.org).

APPLICATION NUMBER	[APPLICANT, PLEASE LEAVE THIS AREA BLANK]
PROGRAM INFORMATION & OVERVIEW	
Date of this Application	5-10-13
Full Name of Individual Treatment Provider/ Program	Sarah J. Lehman
Organizational / Institutional Sponsor (if applicable)	Sanford Bemidji Medical Center
Street Address	1300 Anne St. NW
City, State, Zip	Bemidji, MN 56601
Website URL	
ATTUD Member Contact Name(s)	Sarah Lehman
Telephone	218-333-5017
Fax	
Email Address	sarah.lehman@sanfordhealth.org
Sources of Funding (check all that apply)	<input type="checkbox"/> Federal grants <input type="checkbox"/> State grants / appropriations / tobacco control programs <input type="checkbox"/> Fee for services <input type="checkbox"/> Other in-house funding <input type="checkbox"/> Pharmaceutical industry contracts <input type="checkbox"/> Foundation funding <input checked="" type="checkbox"/> Other, please describe:
Years treatment program has been in existence	Enter year program was started: 12-1-12 Total years in operation: <1 year

Number of tobacco users receiving treatment per year	N/A
Types of tobacco use treated	(Select all that apply) <input checked="" type="checkbox"/> Cigarettes <input checked="" type="checkbox"/> Moist Snuff <input checked="" type="checkbox"/> Cigars <input checked="" type="checkbox"/> Chewing Tobacco <input checked="" type="checkbox"/> Pipes <input type="checkbox"/> Other: Water pipes; bidis; etc
Are your treatment protocols based upon a set of evidenced-based guidelines?	<input checked="" type="checkbox"/> Yes, cite: Mayo Clinic NDC <input type="checkbox"/> No, please explain:
Is there a cost for treatment? (Please indicate whether pharmacotherapy is covered in the cost)	<input checked="" type="checkbox"/> YES, please specify:TBD <input type="checkbox"/> NO What is covered by this cost? (check all that apply) <input checked="" type="checkbox"/> Counseling <input type="checkbox"/> Medication <input type="checkbox"/> Web Access <input checked="" type="checkbox"/> Printed Materials
How many counseling sessions are provided and how long is each session?	Describe: Number of sessions: TBD 30-60 min/session
What treatment medications are provided (directly or indirectly) by the program?	(Check all that apply) <input checked="" type="checkbox"/> Nicotine patch <input checked="" type="checkbox"/> Nicotine gum <input checked="" type="checkbox"/> Nicotine lozenge <input checked="" type="checkbox"/> Nicotine inhaler <input checked="" type="checkbox"/> Nicotine nasal spray <input checked="" type="checkbox"/> Bupropion SR <input checked="" type="checkbox"/> Varenicline (Chantix) <input checked="" type="checkbox"/> Combination of medications Enter any further descriptions here:
Is alternative treatment part of your approach? Alternative treatment approaches are described as: <ul style="list-style-type: none"> • Hypnotherapy • Acupuncture • Laser Therapy • Anti-cholinergic Shot Therapy • Herbal Therapy 	<input type="checkbox"/> Yes (Please describe): <input checked="" type="checkbox"/> No
Are you/your Treatment Specialists (TTS) trained to ATTUD's Core Competencies?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (please explain)
Are you/your TTS required to be certified? (Note: ATTUD recognizes that at this time there is no national or universally recognized certification standard and that all certifications are local)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Do the services provided by your program have oversight by medical staff?	<input checked="" type="checkbox"/> Yes (please describe): <input type="checkbox"/> No
Types of treatment providers in your program (check all that apply):	<input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychologist <input type="checkbox"/> Mental Health Counselor <input type="checkbox"/> Addiction Specialist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Physical/Occupational/Speech Therapist <input checked="" type="checkbox"/> Health Educator <input type="checkbox"/> Social Worker <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist <input checked="" type="checkbox"/> Other (please list): Wellness Specialist

TREATMENT FORMAT(S)

What treatment formats are provided by your program?	(Check all that apply) <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Group <input checked="" type="checkbox"/> Phone <input type="checkbox"/> Web-based
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TREATMENT DIVERSITY

Do you provide treatment in languages other than English?	<input type="checkbox"/> Yes (please list) <input checked="" type="checkbox"/> No, English only
Is your treatment program culturally and/or sexually diverse?	<input checked="" type="checkbox"/> Yes (please explain) <input type="checkbox"/> No (please explain)

ADMINISTRATIVE ASSURANCE

Name and title of official who assumes responsibility for completion of this application	<input checked="" type="checkbox"/> By checking this box, I affirm that the information provided herein is accurate to the best of my knowledge. (Be sure to sign and send the attached Assurance Form)
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