

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	
Full Name of Individual Treatment Provider/ Program	
Organizational / Institutional Sponsor (if applicable)	
Street Address	
City, State, Zip	
Website URL	
ATTUD Member Contact Name(s)	
Telephone	
Fax	
Email Address	
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 type="checkbox"/> Other, please describe:
Years treatment program has been in existence	Enter year program was started: Total years in operation:

Number of tobacco users receiving treatment per year	
Types of tobacco use treated	(Select all that apply) <input type="checkbox"/> Cigarettes <input type="checkbox"/> Moist Snuff <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipes <input type="checkbox"/> Other: Water pipes; bidis; etc
Are your treatment protocols based upon a set of evidenced-based guidelines?	<input type="checkbox"/> Yes, cite: <input type="checkbox"/> No, please explain:
Is there a cost for treatment? (Please indicate whether pharmacotherapy is covered in the cost)	<input type="checkbox"/> YES, please specify: <input type="checkbox"/> NO What is covered by this cost? (check all that apply) <input type="checkbox"/> Counseling <input type="checkbox"/> Medication <input type="checkbox"/> Web Access <input type="checkbox"/> Printed Materials
How many counseling sessions are provided and how long is each session?	Describe:
What treatment medications are provided (directly or indirectly) by the program?	(Check all that apply) <input type="checkbox"/> Nicotine patch <input type="checkbox"/> Nicotine gum <input type="checkbox"/> Nicotine lozenge <input type="checkbox"/> Nicotine inhaler <input type="checkbox"/> Nicotine nasal spray <input type="checkbox"/> Bupropion SR <input type="checkbox"/> Varenicline (Chantix) <input 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 type="checkbox"/> No
Are you/your Treatment Specialists (TTS) trained to ATTUD's Core Competencies?	<input 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 type="checkbox"/> Yes <input type="checkbox"/> No

Do the services provided by your program have oversight by medical staff?	<input 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 type="checkbox"/> Health Educator <input type="checkbox"/> Social Worker <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Other (please list):

TREATMENT FORMAT(S)

What treatment formats are provided by your program?	(Check all that apply) <input type="checkbox"/> Individual <input type="checkbox"/> Group <input 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 type="checkbox"/> No, English only
Is your treatment program culturally and/or sexually diverse?	<input 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 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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ASSURANCE STATEMENT

Name of Treatment Individual / Program:

A formal application has been submitted to ATTUD for listing on the ATTUD website. The ID number of that application matches the one listed above. To the best of our knowledge, I/we attest to the following:

1. All information provided is complete and accurate.
2. Our program is currently active.
3. We agree to notify ATTUD with any significant changes to the information provided above.
4. We understand that if approved, our program information will be viewable on the ATTUD website and downloadable as a PDF file.

Signatures

_____/_____/_____ Date
Tobacco Treatment Provider/Program Director

_____/_____/_____ Date
Program Official (if needed)

Please indicate if either signer is a current ATTUD Member YES NO

After signing above, please do one of the following:

1. Complete this form with your electronic signature, save and email to txproviders@attud.org
2. Sign and scan this form and email to txproviders@attud.org

Your application will be assigned to the review committee once all materials are received. You will be contacted once that process is complete. Please allow 2 – 4 weeks for processing.

Thank you,

ATTUD Communications Chairperson