

Tobacco Cessation Program DoD Civilian Provider Form

To participate in the program, all participating employees are required to complete the following statement prior to enrollment in the program.

The Tobacco Cessation program provides general information, support, resources, and referral for individuals who seek to improve their health by quitting use of tobacco products. The employee is advised of the following:

1. The employee can only request approval of excused absences, not to exceed three (3) hours per week, if the employee has already completed the requisite paperwork for fitness and wellness activities. Otherwise, annual leave is required to participate in tobacco cessation classes.
2. The program does not provide any form of clinical or medical counseling or patient care. The employee should seek his/her civilian provider for such counseling/care.
3. As part of the program, tobacco cessation medication, prescribed by a civilian medical provider, may be provided at government expense as described herein.
 - a. Medications include (1) Zyban (twelve weeks), (2) nicotine replacement therapy (patches, ten weeks), (3) a combination of nicotine replace therapy (patches, ten weeks) and Zyban (12 weeks); and (4) Chantix (three months).
 - b. The civilian provider is responsible for (a) evaluating the employee, (b) advising the employee regarding the medication, side effects, and drug interactions, (c) aiding the employee in making an informed decision regarding the medication, and (d) providing care of the employee while the employee is using the medication.
 - c. The base pharmacist dispenses the medication. The base pharmacist does not provide the employee any counseling or other direct patient care, as defined in AFI 44-119, para 7.8.3. This is solely the responsibility of the civilian provider.
 - d. The employee should tell their civilian provider of all medical conditions and medications he/she is taking.
 - e. The employee should immediately report any side effects or unusual reactions to his/her civilian provider. The base pharmacist and Health and Wellness Center cannot provide advice regarding an employee's side effects or unusual reactions.
 - f. Any medication provided is limited to that necessary for the program. Individuals who do not participate in the program or do not meet program requirements may not be provided medication.
 - g. The base pharmacist, for any reason, may decline to provide medication to the employee.

4. Employee Initials:

- _____ I have read, understand, and agree to comply with the aforementioned provisions.
_____ Participation in the program is voluntary, but attendance in every class is expected.
_____ Participation in the program is subject to supervisory scheduling and approval.
_____ I am responsible for any expenses required to obtain a doctor's evaluation and prescription.
_____ I understand the base will not provide any clinical counseling or medical care.

_____ I will notify my civilian provider immediately of any health concerns, including side effects or unusual reactions to the medications. The Air Force is not responsible for any adverse health effects from such medications.

EMPLOYEE INFORMED CONSTANT:

OFFICIAL CERTIFICATION: I certify, to the best of my knowledge and belief, that the statements herein are true, accurate, and complete. I understand that willful provision of false information is a criminal offense (Title 18, United States Code, Section 1001) and that any person making any false, fictitious, or fraudulent statement may be terminated from employment and may also be subject to other civil and criminal penalties under law.

Employee Signature

Employee Printed Name

Date

PHYSICIAN CERTIFICATION (Required):

Note: The Air Force Varenicline (Chantix) Prescribing Guidelines are attached for your consideration and use with your clinical evaluations. Based on multiple resources and expert clinical advice on the link between Chantix and suicidal behavior, AF recommends that Chantix be prescribed after an appropriate assessment as described in the attached guideline.

I certify that I have evaluated the above-named employee. I have concluded that the person is medically fit for participation in the tobacco cessation program. After considering the employee's medical history and securing the employee's informed consent, I have prescribed the medication. I have briefed the employee regarding the side effects, risks, and drug interactions, and the requirement to seek immediate care from myself or other civilian provider in such circumstance.

Returned: (a) Prescription w/ applicable restrictions and (b) Employee's Informed Consent

Civilian Provider Signature

Civilian Provider Printed Name

Date

PRIVACY ACT STATEMENT: The following information required by the Privacy Act and is provided for your information: **AUTHORITY:** 10 U.S.C. § 8013; **PURPOSE:** To advise individuals of the restrictions regarding prescription medication in the tobacco cessation program; **ROUTINE USES:** The information you provide is a personnel record and will be retained in conjunction with the tobacco cessation program; **DISCLOSURE:** Optional. Any information you provide will be used for official purposes. Your failure to provide information may limit your ability to obtain medications under the tobacco cessation program.
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