

**TENNESSEE COLLEAGUE ASSISTANCE  
FOUNDATION (TCAF)**

**Forms & Contracts**

**TENNESSEE COLLEAGUE ASSISTANCE FOUNDATION**  
is an Affiliated Foundation of the  
Tennessee Psychological Association

**TENNESSEE COLLEAGUE ASSISTANCE FOUNDATION (TCAF)**  
**418 North Maney Avenue**  
**Murfreesboro, TN 37130**  
**(877) 895-2248**  
**www.tcafonline.org**

**Referral Form**

Thank you for your referral to the TCAF. Please complete the form below and fax it to the TCAF at (615) 895-2049. Your fax should be accompanied by a telephone call to the above-listed number to inform us of your referral. Feel free to leave a message on our voicemail if you are unable to speak with anyone, and we will acknowledge receipt of your voicemail message within 24 hours.

REFERRAL MADE BY: \_\_\_\_\_ DATE OF REFERRAL: \_\_\_\_\_

REFERRAL CONTACT NUMBER: \_\_\_\_\_

NAME OF COLLEAGUE: \_\_\_\_\_

COLLEAGUE'S ADDRESS: \_\_\_\_\_

\_\_\_\_\_

COLLEAGUE'S CONTACT NUMBER: \_\_\_\_\_

STATUS OF LICENSE (i.e., application in progress, active): \_\_\_\_\_

TYPE OF LICENSE (i.e., psychologist, psychological examiner): \_\_\_\_\_

THIS COLLEAGUE IS:

\_\_\_\_\_ Aware of his/her referral to the TCAF.

\_\_\_\_\_ Unaware of his/her referral to the TCAF (e.g., complaint filed by a client or co-worker, intervention may be required).

NATURE OF THE PROBLEM: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NOTE: If the colleague is aware of his/her referral to the TCAF, we ask that you provide him/her with a TCAF Introduction Form (enclosed). As per the TCAF Introduction Form, the colleague is to contact the TCAF within 10 business days of the date of referral (listed above). Should the colleague fail to contact the TCAF within 10 business days, the TCAF will inform you of the colleague's failure to initiate contact. If the colleague is unaware of his/her referral to the TCAF, we will update you regarding the status of our initiation of contact within 10 business days.

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## **TCAF Introduction Form**

The Tennessee Colleague Assistance Foundation (TCAF) is a non-profit Tennessee corporation developed by psychologists for the specific purpose of providing monitoring services for mental healthcare professionals. The TCAF is an affiliated foundation of the Tennessee Psychological Association (TPA). The TCAF currently has a contract with the Tennessee Board of Examiners (BOE) in psychology, and the scope of our services is designed to assist mental health practitioners who may be experiencing difficulties causing professional impairment, or who may need assistance with licensure issues. Referrals to the TCAF generally come from three sources: 1) the BOE - both intervention and non-intervention, 2) self-referral, and 3) other referral - both intervention and non-intervention (e.g., family member, colleague or other professional, patient). To obtain assistance from the TCAF, contact should be initiated by calling the above-listed telephone number. Please feel free to leave a message on our voicemail if you are unable to speak with anyone, and we will return your call within 24 hours. Your first contact with a TCAF professional will likely involve a brief interview for the purposes of gathering background information. The TCAF is a cutting-edge monitoring agency, and as such you can be assured that your case will be handled professionally and discretely.

**PLEASE NOTE:** If you are a mental healthcare practitioner referred by the BOE, you must initiate contact with our organization with 10 business days of your date of referral (found on the TCAF Referral Form completed by the BOE). Should you fail to initiate contact with our organization within this time period, the BOE will be informed of your failure to comply.

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**Colleague Encounter Checklist**

CASE NUMBER: \_\_\_\_\_ NAME: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ DATE OF REFERRAL: \_\_\_\_\_

Referral form received? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Contact with referral source? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Contact with colleague? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Associate Directors contacted? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Meeting date with colleague established? YES NO DATE: \_\_\_\_\_

DATE OF MEETING: \_\_\_\_\_

NOTES: \_\_\_\_\_

Initial meeting held? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Informed consent forms completed? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Conflict of interest forms completed? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Evaluation/treatment forms given? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

Results/discharge summaries received? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

RAMP contract completed? YES NO DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_



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**Intake Form**

NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_

MOBILE PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

TYPE OF SERVICES PROVIDED: \_\_\_\_\_

LICENSURE STATUS: \_\_\_\_\_

HISTORY: \_\_\_\_\_

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\_\_\_\_\_

DISPOSITION: \_\_\_\_\_

\_\_\_\_\_

SIGNED: \_\_\_\_\_

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**Informed Consent**

I, \_\_\_\_\_, do hereby authorize the Tennessee Colleague Assistance Foundation (TCAF) to execute its duties with respect to professional monitoring of my case. I understand that the TCAF's execution of monitoring duties includes obtaining background information regarding my case, and as such I hereby authorize the TCAF to contact the following individuals or agencies for purposes of obtaining information:

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Further, I understand that this informed consent includes permission for the TCAF to disclose sensitive information about my case to those individuals or agencies named above, including that regarding alcohol or drug abuse, boundary issues, functional impairment, treatment progress, and health status. I also understand that I may withdraw from the TCAF program at any time by informing the TCAF in writing, and I understand that withdrawal from the TCAF's program will result in the TCAF informing the referring agency (if applicable) of my withdrawal.

This informed consent shall remain in force for five years from the date of signing unless specifically revoked by me in writing. I understand that the purpose of obtaining information is a good faith effort by the TCAF to determine my status with regard to matters affecting professional practice.

\_\_\_\_\_  
Signature (Colleague)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (TCAF Representative)

\_\_\_\_\_  
Date

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**Information for Evaluating Facilities**

NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

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The above-named colleague has been referred to our organization, and we have contracted with this individual to provide monitoring services. Our contact with this colleague has resulted in the decision to refer him or her for a psychological evaluation. Your facility has been chosen to perform this service, based in large part on your facility's history of providing comprehensive, thorough, and professional evaluations.

As part of the conclusions of your evaluation, it is our hope that you will be able to provide some measure of the colleague's functional impairment. Specifically, we ask that you describe in detail the nature and the severity of the functional limitations of any disorder with which the colleague is diagnosed. We also request that you provide specific recommendations regarding the colleague's need for treatment and aftercare.

It should be noted that the above named colleague is responsible for any and all costs that may be incurred as part of this evaluation. We have obtained a release of information to communicate with your facility regarding this case. As such, please feel free to contact us should you have any questions or concerns about this evaluation.

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**Information for Treatment Facilities**

NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

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The above-named colleague has been referred to our organization, and we have contracted with this individual to provide monitoring services. Our contact with this colleague has resulted in the decision to refer him or her for treatment. Your facility has been chosen to perform this service, based in large part on your facility's history of providing comprehensive, thorough, and professional treatment.

As part of your discharge summary, it is our hope that you will be able to provide some measure of the colleague's functional impairment. Specifically, we ask that you describe in detail the nature and the severity of the functional limitations of any disorder with which the colleague is diagnosed. We also request that you provide specific recommendations regarding the colleague's need for aftercare, including recommendations for professional monitoring.

It should be noted that the above named colleague is responsible for any and all costs that may be incurred as part of his or her treatment. We have obtained a release of information to communicate with your facility regarding this case. As such, please feel free to contact us should you have any questions or concerns about the above-named individual. Finally, we would appreciate any updates you may be able to provide regarding this individual's progress in treatment.

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**Release of Information**

I, \_\_\_\_\_, do hereby authorize and request that

\_\_\_\_\_

release information regarding my case to: \_\_\_\_\_

\_\_\_\_\_

This authorization to release information shall remain in force for five years from the date of signing unless specifically revoked by me in writing. This consent to release information includes permission to disclose sensitive information, including that regarding alcohol or drug abuse, treatment progress, and health status.

I understand that the purpose of obtaining information is a good faith effort by the Tennessee Colleague Assistance Foundation (TCAF) to determine my status with regard to matters affecting professional practice.

\_\_\_\_\_  
Signature (Colleague)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (TCAF Representative)

\_\_\_\_\_  
Date

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**Acknowledgement of Policies & Procedures**

Dear Colleague:

Attached are the policies and procedures of the Tennessee Colleague Assistance Foundation (TCAF). Please sign below to indicate you have read, understand and agree to comply with these Policies & Procedures.

\_\_\_\_\_  
Signature (Colleague)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (TCAF Representative)

\_\_\_\_\_  
Date

# **TENNESSEE COLLEAGUE ASSISTANCE FOUNDATION (TCAF)**

## **Rehabilitation & Aftercare Monitoring Program**

### Information and Guidelines

Welcome to the Tennessee Colleague Assistance Foundation (TCAF) Rehabilitation and Aftercare Monitoring Program (RAMP). Your RAMP is operated by the TCAF as part of the contracted services provided for impaired professionals. RAMP is designed to assist you with your re-entry into your profession, and with documentation of active participation in your rehabilitation. The TCAF's advocacy for a professional is based in large part on that professional's adherence to the conditions outlined in his or her RAMP contract.

Impairment may stem from many causes, and the type and length of rehabilitation varies by individual response as well as by etiology. Your RAMP program is designed with your particular needs in mind, and the TCAF will periodically review your progress toward recovery goals with you. Generally, the duration of your enrollment in the RAMP is five years (60 months). Failure to comply with all aspects of the requirements outlined in your RAMP contract, (which will be supplied to you in the form of a written agreement) may, upon evaluation by the TCAF, be cause for termination of your active enrollment status with the TCAF, and consequently may mean withdrawal of our advocacy and/or reporting of your termination with the TCAF to the Tennessee state Board of Examiners in Psychology (as per your written contract). You will receive prior notification of your lack of compliance before final termination from RAMP. By consent of the TCAF, and at your written request, you may be provided one opportunity to reestablish compliance before removal from enrollment.

In exchange for your adherence to treatment recommendations given you and the conditions of your RAMP contract, you will be maintained on the TCAF's roster of active enrollees, and the TCAF will provide documentation to any necessary agencies of your enrollment during your continuing rehabilitation. The TCAF will also actively advocate for you to the Tennessee state Board of Examiners in Psychology, professional organizations, and employers regarding your fitness to return to practice, as long as conditions of the RAMP contract are met.

Enrollment in the RAMP is initiated upon completion of mandated evaluations and/or treatment programs, and upon subsequent, prompt signing of a written RAMP contract with the TCAF. Subsequently, periodic meetings will be arranged with you to discuss your progress toward treatment and work goals and to review any problems you may have. The TCAF will coordinate appropriate monitoring activities including, but not limited to, requesting interview with you, obtaining periodic progress reports from professionals involved in your care and rehabilitation, reviewing discharge plans, and requesting urine/blood screens when appropriate. It is your responsibility to comply with the TCAF's meeting schedule, with its monitoring requests, and to facilitate communication with and between all participants of your rehabilitation and recovery program. It should be noted that furnishing of proper signed consent forms is considered an integral part of the facilitation of the process.

You may be expected to be to attend a number of self-help groups, to obtain a self-help sponsor and to attend *Caduceus* groups or other special recovery groups for impaired professionals. In addition an AA/NA sponsor (in the case of chemical dependency) and a workplace monitor is strongly suggested. All particulars will be included in your written contract, which will be updated periodically with you. At the completion of five years of active participation in the RAMP, the TCAF will review with you your status and provide you with recommendations regarding further participation and planning.

You are expected to be personally responsible for costs incurred in your treatment and rehabilitation.

I, \_\_\_\_\_, have read and understand the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For the TCAF Director of Services, and Associate Directors of Services:

TCAF Member: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TCAF Member: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TCAF Member: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Rehabilitation & Aftercare Monitoring Program Contract**

CASE NUMBER: \_\_\_\_\_ Date: \_\_\_\_\_

TO: \_\_\_\_\_  
(Professional)  
\_\_\_\_\_  
\_\_\_\_\_

As part of your RAMP contract, it is the recommendation of the TCAF that you:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We will review these recommendations with you any time you request. We ask that you carry them out promptly. Keep us informed by telephone or email, of your progress by contacting:

Director of Services: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_

Associate Director of Services: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_

Associate Director of Services: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_

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**Rehabilitation & Aftercare Monitoring Program Contract**

AGREEMENT

The Tennessee Colleague Assistance Foundation (TCAF), and \_\_\_\_\_ agree that he/she may be enrolled and maintained as a participant in the Committee's Rehabilitation & Aftercare Monitoring Program (RAMP).

Initial assessment/evaluation and/or treatment completed on (date): \_\_\_\_\_

Reentry (mark and initial those which do not apply):

1. Participant will attend \_\_\_\_\_ (indicate number and kind of self-help meetings) per week. These sessions will be closed meetings.
2. Participant agrees to obtain a sponsor and to furnish this name to the TCAF.
3. Participant agrees to facilitate communication and exchange of information regarding her/his recovery progress between the TCAF and persons involved in her/his rehabilitation.
4. Participant agrees to take part in medical treatment and/or psychotherapy, which has been professionally recommended.
5. Participant agrees to meet with the TCAF and/or its designee(s) on a regular basis.
6. Participant agrees to furnish observed random urine screen and/or blood screens (at the expense of the participant) at the request of the TCAF.
7. Participant agrees to notify TCAF immediately in the event of prescribed treatment of a condition in which the use of a mind/mood altering medication is contemplated.

Additional conditions:

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One year from the date of this contract, participant and the TCAF will conduct a full review of progress. Assessment of recovery and any further recommendations for rehabilitation will be provided to participant.

I, \_\_\_\_\_, certify that I have read the above Agreement, that I understand the above conditions for admission and participation in the Rehabilitation & Aftercare Monitoring Program (RAMP), and that I agree to abide by the conditions set forth. Should I choose to discontinue this program without the TCAF's approval, I understand that the TCAF will contact the Tennessee state Board of Examiners in Psychology and/or the TPA/APA Ethics Committee(s) for consideration of possible ethical violations.

I understand that all costs of rehabilitation and treatment are my personal responsibility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For the TCAF Director of Services, and Associate Directors of Services:

TCAF Member: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TCAF Member: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TCAF Member: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant: Please print name, permanent address, and telephone. List address where you may be contacted.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

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**Meeting Minutes**

CASE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

LOCATION: \_\_\_\_\_

ATTENDEES: \_\_\_\_\_

\_\_\_\_\_

Notes

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NEXT MEETING: \_\_\_\_\_

SIGNED: \_\_\_\_\_

