



Primary Care Provider Agreement

Shape Up RI is working to encourage patients to register for wellness programs, including the upcoming Shape Up RI competition. Together, as a partner in our Shape Up RI Doctors Program, we can enhance our ability to engage patients in wellness programs in your area.

Starting in December 2009, participating providers receive, at no cost:

- An opportunity to refer patients to effective health promotion programs that foster Patient Self-Management Support
- A wellness kit for your patients that includes:
 - Tips and information on physical activity, healthy eating, and wellness
 - Information on free and reduced cost wellness and fitness programs in your local area
- Health promotion materials for your office
- End of competition reports on patient results

As a Shape Up RI Provider, What Do I Do?

- Sign an office agreement form and provide brief descriptive data about your clinical practice
- Agree to have your receptionist or other designated staff in your office:
 - Distribute Shape Up RI wellness packet starting in December 2009
 - Collect referral cards from patients
- “Prescribe” wellness to your patients by encouraging them to be physically active and take part in a wellness program

What is Shape Up RI?

- An evidence-based (Wing, et al, 2009) employer and community wellness program
- A fun, motivating way to improve health and fitness through teamwork, competition and peer support
- A 12-week, self-paced wellness program that encourages participation through:
 - Forming teams of 5-11 people, friendly competition and peer support
 - Online tracking, based on self-defined goals for pedometer steps, weight loss, and/or exercise hours

Public Statements

_____ Please initial in acceptance of this statement: Shape Up RI has the right to refer to your office in our sales and marketing materials and presentations and to publish a press release announcing your office’s participation in the Shape Up RI Program.

Acceptance of Program Agreement

By signing below, you acknowledge that you have read and accepted the terms of this agreement.

Name Printed

Signature

Date



Office Information

Office or organization name: _____

Primary care provider name(s): _____

Number of practitioners in your office: _____

Type of practice/specialty (e.g., Primary Care, Cardiology, Endocrinology, Nursing, Physical Therapy, etc) _____

Number of patients served (i.e., number in your caseload, or number seen per year -- circle one)

<1000 1000 – 2500 2501 – 5000 5000 – 7500 7500 – 10,000

Number of office(s) _____

For each office in your organization:

Office manager / contact _____	Office manager / contact _____
Location _____	Location _____
Phone number _____	Phone number _____
Email address of contact _____	Email address of contact _____

Office manager / contact _____	Office manager / contact _____
Location _____	Location _____
Phone number _____	Phone number _____
Email address of contact _____	Email address of contact _____

Would you like to enroll your office in Shape Up RI and invite your office staff to participate in this wellness program?

Yes No Unsure