Client Profile

**Company Information**

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| **Organization** |
| Organization Legal Name: |           |
| Alias Name(s): |           |
| Corporate Address: |           |
| Locations: | Please include separately in excel format (locations, addresses and population) |

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| **Population** |
| Number of Independent Physicians: |           |
| Number of Employed Physicians: |           |
| Number of Advance Practice Clinicians: |           |
| Number of Executives: |           |
| Number of Employees: |           |

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| **Web and Mobile App Login** |
| Username: |           |
| Password: | **vitalworklife** |
| Select a username unique to your organization. Please do NOT include symbols, hyphens, spaces or uppercase letters in the selected username.This will be used by all covered employees when logging onto the website and mobile app to access resources. |

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| **Key Dates & Frequency of Physician and Leadership Meetings** |
|  Physician | New Physician Orientation: |           |
| Well Being Retreats: |           |
| Grand Rounds: |           |
| Department Meetings: |           |
| Annual Meetings or Events for Physicians and/or Spouses:  |           |
| Other (Specify): |           |
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| Leadership | Department Chairs: |           |
| Practice Committee: |           |
| Medical Executive Committee: |           |
| Wellness/Well Being Committee: |           |
| Leadership Team: |           |
| Other (Specify): |           |

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| **Budget Information** |
| Timeline and Deadline for Budget Consideration: |           |
| Fiscal Budget Period: | [ ] Calendar [ ] Other           |
| Decision Maker with Budget Signature Authority: |           |

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| **Other** |
| Formal Plan for Recognizing and Dealing with Disruptive Behavior: | [ ] yes [ ] no If yes, please attach policy |
| Substance Abuse Policy: | [ ] yes [ ] no If yes, please attach policy   |
| Well Being Committee: | [ ] yes [ ] no If yes, please attach charter  |
| On-Site Staff/Position(s) specifically designed to improve/support physician well being: | [ ] yes [ ] no Comments:           |
| Internal/External EAP: | [ ] yes [ ] no If yes, please identify provider and contact information:           |
| Internal Coaching or Mentor Program: | [ ] yes [ ] no Comments:           |
| Leadership Development Offerings: | [ ] yes [ ] no Comments:           |
| Provider Development Offerings: | [ ] yes [ ] no Comments:           |
| Organizational Development/Training Department: | [ ] yes [ ] no Comments:           |

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| **Additional Information** |
|           |

**Contact Information**

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| **Executive Sponsor** |
| Name: |           |
| Title: |           |
| Preferred Email: |           |
| Phone: |           |
| Address (if different from Corporate): |           |

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| **Program Manager**  |
| Name: |           |
| Title: |           |
| Preferred Email: |           |
| Phone: |           |
| Address (if different from Corporate): |           |

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| **Invoices** |
| Name: |           |
| Title: |           |
| Preferred Email: |           |
| Phone: |           |
| Address (if different from Corporate): |           |
| Secondary Invoice Contact Person: |           |

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| **Marketing/Communications** |
| Name: |           |
| Title: |           |
| Preferred Email: |           |
| Phone: |           |
| Address (if different from Corporate): |           |
| Available Physician Communication Channels: | [ ] Internal Newsletters[ ] Intranet[ ] Email Communications[ ] Letters to Home[ ] Other (Please identify additional vehicles):           |

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| **Other Contacts for Program Information (if applicable)** |
| Director of Medical Staff/Credentialing: |           |
| Recruiting and Retention: |           |
| CME -Training and Education: |           |
| Other business partners (HR, Chiefs and Chairs, Medical Directors & Officers): |           |
| Well Being Committee VP or Director (If applicable): |           |

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| **For VITAL WorkLife Use Only:** |

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| **Account Team (NAE/AM)** |
|           |

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| **Key Initiative (Goal)** |
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| **Stage of Well Being Journey** |
|           |

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| **Measures of Success (Minimum of 5)** |
|           |

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| **Well Being Advocate** |
| Name: |           |
| Title: |           |
| Preferred Email: |           |
| Phone: |           |

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| **Well Being Advocate** |
| Name: |           |
| Title: |           |
| Preferred Email: |           |
| Phone: |           |

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| **Well Being Advocate** |
| Name: |           |
| Title: |           |
| Preferred Email: |           |
| Phone: |           |

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| **Additional Well Being Advocates** |
|           |