



## TREATMENT / REHABILITATION CHECK-IN FORM



The purpose of this form is to have the employee being referred by the Department of Administration's Employee Assistance Program (EAP) to check into a rehabilitation program from the Department of Mental Health and Substance Abuse (MHSA) or any treatment facility approved by MHSA to verify that the employee had made an appointment with a Substance Abuse Counselor within **10 business days from the date of the EAP Referral date.**

<b>PART A: EMPLOYEE INFORMATION</b> <i>(To be completed by Department/Agency's EAP Representative)</i>	
Employee's Name: _____ Social Security Number: <u>XXX-XX-</u> _____	
Position Title: _____ Date of Birth: _____	
Department: _____ Section: _____	
Mailing Address: _____	
Designated Representative Name: _____	
Designated Representative Signature: _____	
Designated Representative Email: _____ Telephone: _____	
EAP Referral Date: _____	
<b>PART B: Department of Mental Health &amp; Substance Abuse</b> <i>(To be completed by a Substance Abuse Counselor/Professional) NOTE: Employee must present form within 10 business days from the EAP Referral date.</i>	
Please complete the section below that is relevant to this referral.	
Today's Date: _____ Date of Initial Appointment: _____	
Substance Abuse Counselor Name: _____	
Substance Abuse Counselor Signature: _____	
Position Title: _____ Email: _____	
<b>PART C: (To be completed by the Department of Administration – Drug-Free Workplace Coordinator / EAP Administrator)</b>	
_____ Signature of DOA DFWP Coordinator / EAP Administrator	DFWP – EAP STAMP RECEIVED:

**\*\*\*\*\* Please forward all documents in DUPLICATE to DOA \*\*\*\*\***