



EMPLOYEE ASSISTANCE PROGRAM SUBSTANCE ABUSE REFERRAL



The purpose of this form is to provide classified employees the opportunity to utilize the Employee Assistance Program (EAP), to undergo treatment and rehabilitation counseling relating to Substance Abuse.

NOTE: *(Applies only if the employee is not dismissed by the appointing authority. Enrollment into the Rehabilitation program does not prevent the appointing authority from dismissing an employee regardless, if this is a "First Offense").*

PART A: EMPLOYEE INFORMATION <i>(To be completed by the Department/Agency DER / EAP Representative)</i>	
Employee's Name: _____	Social Security Number: XXX-XX-_____
Position Title: _____	Date of Birth: _____
Department: _____	Section: _____
Immediate Supervisor's Name: _____	EAP Referral Date: _____
PART B: REASON FOR REFERRAL <i>(To be completed by the Department/Agency EAP Representative)</i>	
Please fill in the sections below that is relevant to this referral. If sufficient space is not available, please attach supplemental documents relevant to the employee.	
<u>I. SUBSTANCE ABUSE REFERRAL</u>	
<u>VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE:</u>	
<input type="checkbox"/> Failed drug test	
(Chain of Custody Form #: _____ Medical Review Date: _____)	
<input type="checkbox"/> Drug/Alcohol related arrest, charged, indicted or convicted for a drug-related offense (Attached Documents)	
<u>II. "SAFE HARBOR" REFERRAL</u>	
<input type="checkbox"/> "Safe Harbor" Referral Form	
<u>III. SELF-ADMISSION REFERRAL</u>	
<input type="checkbox"/> All other Referrals, other than "Safe Harbor"	



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PART C: EMPLOYEE AGREEMENT *(To be completed by the Employee)*

IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL CANNOT BE PROCESSED WITHOUT “YES” INDICATED BELOW AND EMPLOYEE’S SIGNATURE:

I understand that my department/agency is referring me to the Employee Assistance Program (EAP). I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein.

____ **Yes**, I elect to participate in the Employee Assistance Program (EAP) and any cost of treatment and rehabilitation is to be at my own expense. I shall refrain from illegal use of drugs/abuse or misuse of prescribed medication. Failure to adhere to these terms or the failure to pass any drug test shall be grounds for disciplinary action up to and including dismissal. I understand that if I was referred through the “Safe Harbor” provision, I’m insulated from a disciplinary action. If my referral is not under a “Safe Harbor” exemption, I am aware the department/agency shall issue an adverse action to me, up to and including *dismissal*, pursuant to Rule 11.400 of the Personnel Rules and Regulations. While undergoing treatment, I will not be assigned to safety sensitive duties and responsibilities.

____ **No**, I do not elect to participate in the EAP. I understand that I will be issued an **adverse action up to and including *dismissal***, pursuant to Rule 11.400 of the Personnel Rules and Regulations for failure to comply with the Drug-Free Workplace Program.

Employee Signature

Last 4 digits of SSN#

Date

PART D: *(To be completed by the Department/Agency EAP Representative)*

Witnesses:

Signature of Agency/Department DFWP EAP Representative

DER PRINT NAME

Signature of Agency/Department Head

Date

Please forward all documents in DUPLICATE to the Department of Administration

PART E: *(To be completed by the DOA – Drug-Free Workplace Coordinator / EAP Administrator)*

<p>_____ Signature of DOA DFWP Coordinator / EAP Administrator</p>	<p>DFWP – EAP STAMP RECEIVED:</p>
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***** NOTHING AS FOLLOWS *****