



SAFE HARBOR ADMISSION REFERRAL FORM



The purpose of this form is to provide a classified employee the opportunity to come forward and utilize the “Safe Harbor” provision, under the Drug-Free Workplace Policy (DFWP) to voluntarily seek treatment and rehabilitation counseling relating to substance abuse. Employees that utilize “Safe Harbor” are insulated from disciplinary action up to and including dismissal. However, positions that have been identified as a Test Designated Position (TDP) are not eligible to claim “Safe Harbor”, pursuant to Public Law 31-28. In addition, an employee must meet criteria of “Safe Harbor” in accordance with the DFWP. The following conditions below outline the guidelines that the employee must adhere to:

This is to certify that I, _____, (whose position title is) _____, have voluntarily admitted to (using illegal drugs/abusing or misusing prescribed medication.) to a supervisor or other higher level management official prior to being (notified of a scheduled random, post-accident, reasonable suspicion/cause testing. In accordance with the “Safe Harbor” conditions, I agree to the following:

(Please initial each provision.)

_____ That my department/agency shall not subject me to disciplinary action up to and including dismissal against me for the admitted acts of illegal use of drugs, including possession, incident to such personal use, especially while I am undergoing treatment and rehabilitation.

_____ I understand that the “Safe Harbor” provision is considered a “First Offense” and should I violate the terms of the “Safe Harbor” agreement or should I fail to pass any subsequent drug test, that such grounds are also reason for any disciplinary action, up to and including dismissal.

_____ I shall enroll and complete the required treatment and rehabilitation program guidelines.

_____ I understand that this treatment and rehabilitation will be at my own expense and that all scheduled appointments that I attend will be charged to sick leave, annual leave, CTO and even leave without pay while I am undergoing this treatment and rehabilitation.

_____ I also understand that, if I am occupying a Test Designated Position (TDP), I will be reassigned to NON-TDP position until I have successfully completed my treatment and rehabilitation program before I can return to my original position.

_____ I agree to be tested by the department/agency as part of or as a follow-up to counseling and rehabilitation.

_____ I hereby authorize the release of my treatment and rehabilitation progress report to my appointing authority or the Employee Assistance Program Coordinator of my department/agency, as well as the Department of Administration’s Drug Free-Workplace Coordinator and Employee Assistance Program Administrator.

_____ I shall refrain from illegal use of drugs/abuse or misuse of prescribed medication and should I fail to pass any subsequent drug test, that such grounds are also reason for any disciplinary action, up to and including dismissal.



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Please forward all documents in **DUPLICATE** to the Department of Administration

PART A: EMPLOYEE INFORMATION *(To be completed by the employee)*

I acknowledge receipt of this form and have read and understood its contents. I voluntarily and willingly admit to foregoing without pressure, intimidation or harassment on the part of management in entering this agreement. Failure to adhere to the terms of this agreement will be grounds for disciplinary action, up to and including dismissal

Employee's Name: _____ **Social Security Number:** XXX-XX-_____

Position Title: _____ **Date of Birth:** _____

Department: _____ **Section:** _____

Date: _____

PART B: DEPARTMENT/AGENCY INFORMATION *(To be completed by the DER Representative)*

Signature of Agency/Department DFWP DER/EAP Representative

Date

Print Name

Signature of Agency/Department Head

Date

Print Name

PART C: DEPARTMENT OF ADMINISTRATION *(To be completed by DFWP Coordinator / EAP Administrator)*

DFWP – EAP STAMP RECEIVED:

Signature of DOA DFWP Coordinator / EAP Administrator