EMPLOYEE ASSISTANCE PROGRAM
REFERRAL FORM

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 (*To be completed by the Department/Agency DFWP EAP Counselor)*

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

Position Title: _____ **Employee ID**: _____

Department: _____ **Section:** _____

Immediate Supervisor's Name: _____ **EAP Referral Date:** _____

PART B: REASON FOR REFERRAL (*To be completed by the Department/Agency EAP Counselor)*

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.

I. SUBSTANCE ABUSE REFERRAL BY EMPLOYEE'S DEPARTMENT/AGENCY

☐ Failed Drug Test

(Chain of Custody Form #:_____ Medical Review Officer Review Date: _____)

☐ Drug/Alcohol related arrest, charge/indictment or conviction for a drug-related offense. Please attach supporting documents if applicable (i.e., newspaper article, police/court clearances, etc.).

II. "SAFE HARBOR" REFERRAL

☐ Complete "Safe Harbor" Agreement Form

III. SELF-ADMISSION REFERRAL

☐ Complete Self-Admission Agreement Form

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

Please initial and check mark your intention to elect to participate in the Employee Assistance Program. I understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have reviewed 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. 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 for as long as I comply with all requirements. 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 the DOA 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 the DOA Personnel Rules and Regulations for failure to comply with the Drug-Free Workplace Program.

_____ XXX-XX-_____

Employee Name Last 4 digits of SSN

_____ _____

Employee Signature Date

PART D: DEPARTMENT/AGENCY (*To be completed by the Department/Agency DFWP EAP Counselor)*

_____ _____

Signature of Agency/Department DFWP EAP Counselor PRINT NAME / DATE

_____ _____

Signature of Agency Director PRINT NAME / DATE

Please forward all documents to the DOA HR Division Employee Management Relations Branch (671) 475-1249/1185

PART E: DEPARTMENT OF ADMINISTRATION (*To be completed by the DOA EAP Administrator)*

Signature of DOA EAP Administrator	EAP STAMP RECEIVED: