



# SELF-ADMISSION AGREEMENT FORM



The purpose of this form is to provide classified employees and unclassified employees at their management’s discretion, who are not eligible to claim “Safe Harbor” under the Drug-Free Workplace Policy and under Title 10 GCA, Chapter 75, §75107: "Safe Harbor" Exemptions and Restrictions (PL 31-28), to come forward to seek treatment and rehabilitation relating to drug and alcohol substance abuse. **Note: Employees referred through this form are subjected to disciplinary action up to and including dismissal/termination, pursuant to DOA Personnel Rules and Regulations and applicable laws and for failure to comply with the Drug-Free Workplace Program.** The following condition below outlines the conditions that the employee must adhere to:

This is to certify that I, \_\_\_\_\_, as an employee whose position title is: \_\_\_\_\_, have voluntarily admitted to using drugs illegally and/or abusing legal drugs and/or alcohol while on duty, at the workplace or work site to a supervisor or other higher level management official because I desire to seek treatment and rehabilitation for substance abuse. I have done so, knowing that I do not meet the “Safe Harbor” provision. In accordance with this Self Admission Referral, I agree and understand the following: **(Initial each Item)**

**(Please initial each provision.)**

\_\_\_\_\_ My department/agency may subject me to disciplinary action up to and including dismissal/termination for the admitted acts of illegal use of drugs, including possession, and/or abusing legal drugs and/or alcohol while on duty, at the workplace or work site. Such disciplinary action may occur even while I am undergoing treatment and rehabilitation.

\_\_\_\_\_ I understand this is considered a “First Offense” and should I violate the terms of this agreement or should I fail to pass any subsequent drug (and/or alcohol) test, such activities are also grounds for any disciplinary action, up to and including dismissal/termination, as well as removal from my treatment and rehabilitation program.

\_\_\_\_\_ I shall enroll and complete the required treatment and rehabilitation program guidelines. My continued participation in my program is contingent on my compliance and for as long as I am an active employee.

\_\_\_\_\_ I understand that 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, Compensatory Time Off (CTO) and even leave without pay while I am undergoing this treatment and rehabilitation.

\_\_\_\_\_ I also understand that, if I am occupying a Testing Designated Position (TDP), I will be reassigned to a non-TDP position. I may be returned to my position after I have successfully completed my treatment and rehabilitation program.

\_\_\_\_\_ I agree to be subject to monthly drug and/or alcohol testing as part of my counseling and rehabilitation, and agree to be subjected to monthly testing up to one year after successful completion of my counseling and rehabilitation.

\_\_\_\_\_ I hereby authorize the release of my treatment and rehabilitation progress report to my agency director 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 agree to refrain from illegal or prohibited use of drugs and alcohol.



# SELF-ADMISSION AGREEMENT FORM



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

I acknowledge receipt of this form and have read and understood its contents. Failure to adhere to the terms of this agreement will be grounds for disciplinary action, up to and including dismissal/termination.

Employee's Name: \_\_\_\_\_ Social Security Number: XXX-XX-\_\_\_\_\_

Position Title: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Department: \_\_\_\_\_ Section: \_\_\_\_\_

Date: \_\_\_\_\_ Employee's Signature: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Agency/Department EAP Counselor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Agency Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Agency Director

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

\_\_\_\_\_  
Signature of DOA EAP Administrator

EAP STAMP RECEIVED:

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