



TREATMENT / REHABILITATION APPOINTMENT VERIFICATION FORM



The purpose of this form is to verify if the employee being referred under the Department of Administration's Employee Assistance Program (EAP) has made an appointment with a rehabilitation program from the Guam Behavioral Health & Wellness Center (GBHWC) or any treatment facility approved by GBHWC. **The employee has one (1) business day after initial appointment to present this form that has been completed by the Substance Abuse Counselor to his/her Department's EAP Counselor. Failure to submit completed form to EAP Counselor before close of business of deadline will result in disciplinary action.**

PART A: DEPARTMENT/AGENCY *(To be completed by Department/Agency's EAP Representative)*

Employee Name: _____ Social Security Number: XXX-XX- _____
Position Title: _____ Employee ID: _____
Department: _____ Section: _____
EAP Counselor Name: _____ Signature: _____
EAP Counselor Email: _____ Telephone: _____
EAP Referral Date: _____

I understand that I have one (1) business day after initial appointment to present this form that has been completed by the Substance Abuse Counselor to my Department's EAP Counselor. I understand that failure to submit completed form to my EAP Counselor before close of business of deadline will result in disciplinary action.

Employee Signature: _____ Date: _____

PART B: GUAM BEHAVIORAL HEALTH & WELLNESS CENTER (GBHWC) or any treatment facility approved by GBHWC *(To be completed by a Substance Abuse Counselor/Professional)*

Please complete the section below that is relevant to this referral.

Today's Date: _____ Date of Initial Appointment: _____ Employee Attended? Yes ___ No ___

Substance Abuse Counselor Name: _____ Signature: _____

Position Title: _____ Phone No.: _____ Email: _____

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

Completed Form Received by Deadline? Yes ___ No ___

Signature of Department DFWP EAP Counselor

Date

PART D: 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 ****