COMMERCIAL DRIVER’S LICENSE REFERRAL

**INFORMATION AND CONSENT FORM**

I understand the Commonwealth has been informed that I have tested positive for alcohol and/or controlled substances in a recent CDL alcohol/drug test. I understand that in accordance with *The Omnibus Transportation Employee Testing Act*, I am required to be evaluated and comply with any treatment recommendation made by the Substance Abuse Professional. I understand that if, at any time, I fail to meet any of the conditions set forth, the agency CDL Coordinator, my supervisor, union, and other management staff will be notified and disciplinary action, up to and including termination, may be imposed.

# EVALUATION AND REFERRAL

I request and give my consent to be evaluated by the State Employee Assistance Program (SEAP). I understand that I must contact SEAP within 24 hours from the date below. The evaluation will be scheduled promptly and the results will be forwarded to the SEAP program. I understand that SEAP will notify my SEAP Coordinator as to the date and time of my evaluation, whether I kept my appointment or not, and the type of treatment recommendations made by the evaluator. I also agree to accept the recommendations made by the evaluator and will cooperate fully with SEAP and the evaluator. I understand that I must call SEAP at 1-800-692-7459 to arrangement an evaluation session.

**TREATMENT**

If continued treatment is deemed appropriate, I will cooperate fully with the treatment program. I understand that if I do not successfully complete treatment or abide by the rules of the program, discipline up to and including termination may be imposed. I give my consent to allow the treatment program to communicate on an ongoing basis with SEAP. I give my consent to SEAP to communicate on an ongoing basis with my SEAP Coordinator concerning my involvement in treatment, specifically my attendance, progress, prognosis, date and type of discharge, and any other information deemed relevant.

**ALCOHOL/DRUG TESTS**

I agree to undergo alcohol/drug testing as determined by SEAP. Further, I agree to allow this information to be shared with the SEAP-CCO, treatment program, designated management official, CDL Coordinator, SEAP Coordinator, Labor Relations Specialist, union representative, and OA-SEAP. I further authorize, approve, and give my consent to the Medical Review Officer of the third party vendor who performs the specimen collection and testing services to communicate and release to SEAP and my case manager, any and all information obtained either from me, or from the laboratory, pertaining to my alcohol and/or drug tests and pertinent medical history.

**AFTERCARE**

I understand that additional services, treatment, or participation in self help groups may be recommended by the evaluator or treatment program. I agree to provide verification of my participation and allow for ongoing communication between SEAP and the service provider.

**FOLLOW-UP**

I consent to participate in follow-up. Follow-up contacts will be made with the evaluator, treatment programs, aftercare service providers, supervisors, and agency SEAP Coordinator/employer. Follow-up will consist of phone calls or personal contacts for the purpose of assessing progress and to determine if additional services are needed. Follow-up will begin at the time of referral and will continue for one year after the date of discharge from treatment.

**CONFIDENTIALITY/INFORMATION SHARING**

I consent to allow for ongoing communication and sharing of information between SEAP, the evaluator, treatment program, aftercare service provider, supervisor, SEAP Coordinator, CDL Coordinator, employer, union representative, and the Office of Administration SEAP staff. I understand that the information will be limited to only that information necessary to determine compliance and only on a need-to-know basis. The information is considered confidential and will not be shared beyond those identified above. If additional consents/release forms are required by a service provider or other entities, I will provide the necessary consents.

\* \* \* \* \* \* \* \* \* \*

Having read and/or discussed the above conditions, I understand that compliance with the CDL Alcohol and Drug Testing Program is based on my participation in SEAP, successful completion of treatment, aftercare, follow-up, alcohol/drug tests, and my full cooperation with the responsible parties, as cited above. I understand that these conditions and any action taken by the Commonwealth pursuant to this agreement do not indicate and should not be interpreted to indicate that the Commonwealth regards me as having a disability. I understand that I must meet the existing requirements of my job and that if another violation occurs, or if other problems develop, I may be subject to disciplinary action up to and including termination.

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EMPLOYEE NAME (PRINT)

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EMPLOYEE SIGNATURE DATE

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DESIGNATED MANAGEMENT OFFICIAL DATE

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SEAP COORDINATOR DATE

If additional conditions are being imposed, please attach as an addendum.