The following information is needed to effectively assess the needs of the employee and respond to the concerns in the workplace. Please contact WSSD at (717) 787-8575 before completing any employer based referral forms. Please attach all supporting documentation (witness statements, discipline letters, etc.).

Please check: [ ] COCE [ ] CDL [ ] DOC [ ]  LPR [ ]  IPE [ ]  Self Disclosure

If COCE: [ ] Last chance [ ] Substance Abuse Policy [ ] Fitness For Duty

EMPLOYEE INFORMATION:

|  |  |
| --- | --- |
| Name: |  |
| Identifying Information | SS# | Employee ID# | Date of Birth |
| Agency: |  |
| Location: | Worksite  | County |
| Employment Information | Job Title | Date of Hire/Length of Service |
| Major Duties (include copy of job description for IPE/FFD): |  |

***IF POSITIVE DRUG TEST***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Test: | [ ]  Random | [ ]  Return to Duty | [ ]  Post- Accident | [ ]  Reasonable Suspicion |
| Substance Type: |  |

DESCRIBE IN DETAIL – ATTACH ADDITIONAL PAGES AS NECESSARY

|  |  |
| --- | --- |
| Description of Incident(s) leading to employer based referral  |  |
| Past Discipline |  |
| Job Performance |  |
| Time & Attendance |  |
| Known Problems |  |
| Relationships with Others | Coworkers: | Supervisors: |
| Other Information |  |
| EXPECTED DATE OF REFERRAL: |  | TIME, IF KNOWN: |  |

***PERSONS AUTHORIZED TO RECEIVE INFORMATION***

|  |  |  |
| --- | --- | --- |
| **POSITION** | **PRINT NAME** | **PHONE NO(S)** |
| SEAP Coordinator |  |  |
| Back-Up SEAP Coordinator |  |  |
| Labor Relations |  |  |
| Name of Union (AFSCME, etc.) |  |  |
| Union Representative |  |  |
| Supervisor |  |  |
| CDL Coordinator |  |  |
| Other (Name/Position): |  |  |
| **SENT BY:** | **DATE:**  |

**FAX TO: OA-WSSD (717) 772-3153 Workplace Support Services Division**

# Questions – call (717) 787-8575 Office of Administration

##  Bureau of Employee Benefits & Services