CONDITIONS FOR CONTINUED EMPLOYMENT

INFORMATION AND CONSENT FORM

I acknowledge that the Commonwealth has alleged that I have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand that I must agree to, and fully comply with the conditions described below, in order to retain my employment with the Commonwealth. Further, I understand that if at any time I fail to meet any of the conditions set forth, my supervisor, and/or other management staff will be notified and further disciplinary action including termination may be imposed.

# EVALUATION AND REFERRAL

I hereby request and give my consent to be evaluated by the State Employee Assistance Program (SEAP). The SEAP number is 1-800-692-7459. Further, this 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.

# TREATMENT

I agree to accept the preferred recommendation made by the evaluator. 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, further discipline, including termination, can be imposed. I also give my consent to allow the treatment program to communicate on an ongoing basis with SEAP. Further, 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.

# AFTERCARE

I understand that additional services, treatment, or participation in self-help groups may be recommended by the evaluator or treatment program or SEAP, and as a condition of continued employment, I hereby consent to fully participate in those services. Further I agree to provide verification of my participation and allow for ongoing communication between SEAP and the service provider.

# FOLLOW-UP

I hereby consent to participate in follow-up as a condition of my continued employment. Follow-up contacts will be made with the evaluator, treatment programs, aftercare service providers, supervisors, union, and agency SEAP Coordinator/employer. Follow-up will consist of phone calls or personal contacts for the purpose of assessing progress, determining if additional services are needed, and to monitor compliance with the conditions for continued employment. Follow-up will begin at the time of referral and will continue for one year after the date of discharge from treatment. If at any time SEAP determines that additional services are recommended I agree to participate.

# CONFIDENTIALITY/INFORMATION SHARING

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

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

Having read the above conditions, I understand that my continued employment is based on my participation in SEAP, successful completion of treatment, aftercare, follow-up and my full cooperation with the responsible parties, as cited above. I understand that these conditions are based on the conduct that the Commonwealth alleges I engaged in. 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. Further, I understand that I must meet the existing requirements of my job and that if another violation occurs, or if other problems develop, further disciplinary actions, including termination, may be imposed.

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EMPLOYEE SIGNATURE DATE

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UNION SIGNATURE DATE

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LABOR RELATIONS SPECIALIST SIGNATURE DATE

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SUPERVISOR SIGNATURE DATE

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SEAP COORDINATOR SIGNATURE DATE

## Employee Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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