REQUEST FOR SAP SERVICES

Client No._____

Staff:_____

Date/time:_____

Employee Name: _____ SS#:_____

Address: _____

_____

Home phone: _____ DOB:_____

What was the violation and date? (If positive test, indicate below:)_____

Tested positive for: ☐ ALCOHOL Testing level of:_____

☐ DRUGS (specify)_____

Reason for test:	☐ Pre-employment	☐ FMCSA (Federal Motor Carrier Safety Administration)
	☐ Post-accident	☐ FRA (Federal Railroad Administration)
	☐ Random	☐ FTA (Federal Transit Administration)
	☐ Reasonable suspicion	☐ FAA (Federal Aviation Administration)
	☐ Return-to-duty	☐ RSPA (Research & Special Programs)
	☐ Follow-up	☐ USCG (United States Coast Guard)

Current employment status:_____

_____

Employer: _____

Address: _____

_____

DER: _____ Title:_____

Requested by: _____ Title:_____

Phone: _____ FAX:_____

Assigned to: _____ Date/time:_____

Notes: _____

_____

Billing: _____

STATEMENT OF UNDERSTANDING
related to DOT's SAP return-to-duty process

I,_____ acknowledge that_____
(Name of client) (Name of SAP)

and the service agents and/or entities listed below, must disclose to each other and receive from each other pertinent and relevant information regarding:

1. My violation of DOT regulations (prohibited conducts)
2. My drug and/or alcohol test results
3. The SAP's synopsis of my treatment plan
4. The SAP's assessment evaluation and treatment plan
5. Diagnostic information, where applicable
6. Treatment progress reports
7. Program completion information, including discharge summary, if applicable
8. Program involvement dates, attendance reports
9. Other relevant information as it pertains to my return-to-duty process

- ☐ DER (Designated Employer Representative)
- ☐ MRO (Medical Review Officer)
- ☐ EAP
- ☐ SAP Network
- ☐ Treatment provider
- ☐ Education program
- ☐ C/TPA
- ☐ Managed care, insurance carrier, HMO
- ☐ Other _____

The purpose of the exchange of this information is to comply with DOT requirements that must be met before I may take a Return to Duty drug and/or alcohol test, prior to being considered by my employer for returning to the performance of safety-sensitive functions under DOT regulations.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed to outside parties, including future or past employers, without my written consent unless otherwise required by law, or provided for under the DOT regulations, and as specified below.

I understand that communication between service agents/entities is required under U.S. Department of Transportation rules and regulations, and is permitted without my authorization. I understand that the SAP may request information from my treatment provider without my authorization. Should my treatment provider require me to sign a release of information, I understand that I cannot put restrictions or time limits on the release, and I cannot revoke the release. In addition, the regulations permit the SAP to send required reports to my employer, without my authorization. However, in order for the SAP to provide reports to employers other than my current employer, including future employers, the SAP must obtain my written authorization.

_____ _____
Date Signature of client