## **REQUEST FOR SAP SERVICES**

		Client No	
		Staff:	
		Date/time:	
Employee Name:		SS#:	
Address:			
Home phone:	DOB:		
What was the violati	ion and date? (If positive test, indi	icate below:)	
Tested positive for:			
-			
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 employmen	t status:		
P. L			
Employer:			
Address:			
DER:		Title:	
DEK:			
Requested by:			
Phone:		77 A 37.	
Assigned to:		Date/time:	
Notes:			
Billing:	•		

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

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 portomance of safety-energible functions under DOT regulations.  1. 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.  1. 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 in the patient form my repulser provider regulations and is permitted without my authorization. Understand that the SAP may request information from my reatment provider regulation and is permitted without my authorization. Understand t	I,(Name of	acknowledge that client) (Name of SAP)
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Signature of client

Date