AGREEMENT TO PARTICIPATE IN EDUCATION, REHABILITATION OR TREATMENT PROGRAM

PART A

Participation in education, rehabilitation or treatment program is offered to you as an alternative to the following disciplinary action: (State the consequences of the adverse action)

_____

_____

_____

_____

PART B

If you agree to participate, cooperate, and make satisfactory progress in, and complete the program as recommended by the Director, which may include drug and alcohol analysis testing, the disciplinary action above will not be taken or will be mitigated as follows:

_____

_____

_____

_____

PART C

Under any option, satisfactory conduct and satisfactory job performance must be maintained. Your referral for education, rehabilitation or treatment program does not replace your supervisory option to initiate any adverse action against you if unsatisfactory job performance or unsatisfactory conduct continues.

PART D

Your signature below signifies your agreement to participate in the education, rehabilitation or treatment program. Failure to complete your agreement to participate and comply with the treatment program shall result in the disciplinary action indicated in Part A above.

_____ _____

EMPLOYEE'S SIGNATURE BADGE NO. DATE

_____ _____

DEPARTMENT HEAD'S SIGNATURE DATE

DEPARTMENT OF ADMINISTRATION
RELEASE OF INFORMATION FORM (RIF)

As an employee of the Government of Guam, I understand and acknowledge that I have been referred to the Department of Administration's Treatment and Rehabilitation Program. I understand that I must contact the Employee Assistance Program (EAP) within 24 hours for processing and scheduling for a drug assessment with the Guam Mental Health and Substance Abuse Department. I understand that I may voluntarily arrange and schedule for any and all required education, treatment or rehabilitation programs as may be prescribed by the EAP Specialist.

I hereby sign this waiver which releases information about the educational and treatment program in which I will participate. I authorize the release of any and all information regarding my admittance to an outpatient treatment program, the treatment program and progress, how the scheduled treatment will affect my work schedule, and other information which may affect my employment responsibilities.

I will present a copy of this signed waiver to the Guam Department of Mental Health & Substance Abuse Counselor as notification that I am a referral from the EAP as a result of the Drug Screening Program. This form will serve as notice that information must be released to the EAP and DPS, regarding my admittance and treatment schedule for as long as I am involved in treatment and follow-up care. I understand that if I do not contact the EAP, schedule an assessment, provide information regarding my treatment or complete my scheduled treatment sessions, I may be subject to disciplinary action in accordance with the Civil Service Commission's Adverse Action Procedures.

_____

NAME OF EMPLOYEE

_____

DEPARTMENT/DIVISION/SECTION:

_____ _____

SOCIAL SECURITY NO BADGE NO.

_____ _____

SIGNATURE OF EMPLOYEE DATE

Subscribed and sworn to before me this _____ day of 19_____.

_____

NOTARY PUBLIC

My appointment expires: _____

DEPARTMENT OF ADMINISTRATION
EDUCATION OR TREATMENT VERIFICATION FORM

This certifies that the following individual participated in a drug evaluation and was recommended for an education or treatment program as a mandatory referral to the Department of Mental Health & Substance Abuse.

NAME OF EMPLOYEE

SOCIAL SECURITY NO: BADGE NO.:

1. ☐ This individual successfully completed the recommended program. Determination is based on clinical evidence contained in our records that the individual is free of illegal drugs.
2. ☐ This individual failed to successfully complete the recommended program. Determination is based on:
   a. ☐ failure by the individual to participate; and/or
   b. ☐ clinical evidence contained in our records that the individual is <u>not</u> free of illegal drugs.

Clinical evidence includes a drug screening test result. ☐ YES ☐ NO

COMMENTS:

Name of Facility

Signature of Facility's Authorized Signature Date

Signature of Employee Date

Subscribed and sworn to before me this _____ day of 19_____.

NOTARY PUBLIC

My appointment expires: _____

CONFIDENTIAL

E.A.P. REFERRAL FORM

General Instructions: The purpose of this form is to provide information to the Employee Assistance Prgoram (EAP) regarding an employee's poor work performance or conduct when there is reason to believe that the cause may be due to a personal-medical problem. It is important that you fill in the information requested to the best of your knowledge, limiting your responses to the facts, not hearsay and/or assumptions. This information will serve as a means of assessing the employee's problem and will help the EAP to determine the necessary steps needed in assisting the employee in alleviating his/her problem.

Employee's Name:	Social Security No.:	Referral Date:
Home Address:	City, State, Zip:	Date of Birth:
Position Title:	Home Phone:	Work Phone:
Employer:	Employer's Address:	Place of Employment:
Hours of Work:	Days Off:	Referred By:
Position Title:		Telephone Number:
Department/Agency EAP Counselor:	Position Title:	Telephone Number:

REASON FOR REFERRAL

(To Be Completed By The Supervisor of Referred Employee)

Please fill in the sections below that re relevant to this referral. If sufficient space is not available, please attach a supplemental sheet in order that all relevant information is provided. Attach documentation (Letters of Warning, other disciplinary actions and incident reports) to support these disclosures.

ATTENDANCE

No. of Days Absent In Past 12 Months:	Number of Extended Lunch Periods in Past Six Months. (Reasons, if known):	Number of Late Occurrences in the Past Six Months. Reasons (if any).

Pattern (if any) - e.g., Mondays, Friday, after paydays, before and after holidays. Attach leave records for verification.	Other (Please Specify):

JOB PERFORMANCE

(Give Examples of Demonstrated Poor Performance or Conduct)

( ) Lower Quality of Work	( ) Erratic Work Patterns
( ) Decreased Productivity	( ) Failure to Meet Schedules
( ) Increased Errors	( ) Inability to Concentrate
( ) Impaired Judgement Memory	( ) Other (Specify) _____

BEHAVIOR DEMONSTRATED

(Give Examples of a Specific Poor Behavior)

( ) Avoids Superviors or Co-workers	( ) Loss of Interest or Enthusiasm in Job
( ) Less Communicative	( ) Frequent Mood Swings
( ) Usually Sensitive to Advice or Constructive Criticism	( ) Disregard for Safety On The Job
( ) Usually Critical of Supervisor, Co-workers, or Employer	( ) Other _____

Have The Above Issues Been Discussed With The Employee?	Has The Employee Been Referred For Special Medical Examination?
( ) Yes ( ) No	( ) Yes ( ) No
Supervisor's Signature:	Date:

THIS SECTION TO BE COMPLETED BY EMPLOYEE

I understand that I am being referred by my employer to the Employee Assistance Program (EAP). I also understand that my signature below does not reflect my agreement/disagreement to any of the issues raised. My signature verifies that I have seen the referral and all documentation contained therein.

_____ Yes, I will participate in the Employee Assistance Program.
I am reponsible for all costs of treatment and rehabilitation.

_____ No, I will not participate in the Employee Assistance Program.

_____ _____
Employee's Signature DATE

Please forward all documents in **DUPLICATE** to:

Department of Administration
Division of Personnel Management (EMR Branch)
Employee Assistance Program
P. O. Box 884, Agana, Guam 96932

If you have any questions, please call the Division of Personnel Management at 475-1131/1225.

EAP FORM #1 (5/97)

LETTER OF CERTIFICATION

REFERRAL FOR DRUG AND ALCOHOL ASSESSMENT

To: Department of Mental Health and Substance Abuse
790 Governor Carlos G. Camacho Road, Tamuning, Guam 96911
Telephone: 647-5440/5325 Facsimile: 649-6948

From: _____ ☐ Alternative Sentencing Office (ASO) ☐ Probation Office (PrO)
_____ ☐ Parole Services Division (PaO) ☐ Employer (EAP)

Reference: Client's Name:_____ S.C. Criminal Case No(s).____

Subject: **Referral for Intake and Drug & Alcohol Assessment**

_____ _____ _____
Name of Referring ASO/PrO/PaO/EAP Signature of ASO/PrO/PaO/EAP Date

Note: This referral must be accompanied with client's Court Order and a Consent for Release of Information.

To: ☐ Alternative Sentencing Office (ASO)
Telephone: 475-3194 Facsimile: 477-4944

☐ Probation Office (PrO)
Telephone: 475-3194 Facsimile: 477-4944

☐ Parole Services Division (PaO)
Telephone: 473-7001 Facsimile: 473-7009

☐ Employer (EAP)

From: Intake Unit, Department of Mental Health and Substance Abuse

Please be advised that the above-referenced Client:

☐ Was seen for **Intake/Drug & Alcohol Assessment** on _____.
☐ Failed to show for **Intake/Drug & Alcohol Assessment** on _____.
☐ Case closed as of date _____,

DMHSA Treatment Recommendation is:

ADULT PROGRAM ---

☐ 6-weeks New Beginnings Intensive Rehabilitation Program.
☐ 10-weeks Intensive Outpatient Program for Substance Abuse.
☐ No treatment recommended.
☐ 40-weeks New Beginnings Extended Rehabilitation Program for Substance Dependence.
☐ Other:_____

ADOLESCENT PROGRAM ---

☐ 8-weeks Intensive Outpatient Program (IOP) Program.
☐ 3-weeks Drug and Alcohol Prevention Education.
☐ No treatment recommended.
☐ 8-weeks Drug and Alcohol Prevention Education.
☐ Other:_____

ADDITIONAL ---

☐ _____ Sessions attendance with ☐ Alcoholic Anonymous, ☐ Narcotic Anonymous, ☐ Al-Anon, ☐ Alateen
☐ Discharged from Treatment due to:
  ☐ Rules Violations THREE times.
  ☐ Failure to attend sessions; Client's last attendance was on date _____; case closed as of date _____.
  ☐ _____; case closed as of date _____.
☐ Alternative Treatment Program _____.
☐ **SUCCESSFUL COMPLETION** of recommended Treatment on date _____; case closed as of date _____.

_____ _____ _____
Name of Clinical Staff Signature of Clinical Staff Date

CONSENT FOR RELEASE OF INFORMATION

I, _____, agree to the attached referral; and furthermore, I consent for Department of Mental Health and Substance Abuse, Intake and Drug & Alcohol staff, to release information to my ASO (Alternative Sentencing Officer) PrO (Probation Officer), PaO (Parole Officer), or EAP (Employer) relative, **only**, to my appointment(s) attendance and recommended treatment program. I understand that this referral and compliance for Drug and Alcohol treatment is a requirement of my alternative sentence probationary/parole terms or the Government of Guam Drug-Free Workplace policy.

_____ _____

Signature of Client Date

_____ _____

Witness (Name of ASO/PrO/PaO/EAP) Signature of ASO/PrO/PaO/EAP Date