CONFIDENTIAL

Employee Assistance of the Pacific
Referral Form for DOT-SAP and non-DOT Assessments

TO BE COMPLETED BY SUPERVISOR OR PERSONNEL OFFICE ***(Incomplete forms may result in delay of evaluating employee)***

Employee Name:		**Position:**	**Bargaining Unit:**	
Company:				
Department:		**Division:**		
Designated Employer Representative (DER):			**Company Phone:**	
Alternate (DER):				
Employee's Home Address:				
Home Phone:	**Mobile Phone:**	**Business Phone:**	**Birth date:**	**Last 4 SSN (DOT only):**

☐ **Random** ☐ **Voluntary Admission – See notes below under supervisor comments** ☐ **Return to Duty**
☐ **Pre–employment (or transfer to safety-sensitive duties)** ☐ **Reasonable Suspicion** ☐ **Post-Accident** ☐ **Follow-Up**

Date of Test: **Drug Test Positive For:** ☐ **Breath Alcohol Positive** ☐ **BAL:_____**

For FMCSA CDL Drivers:
CDL Number: **State of Issuance:**

This Test was a: (Please check one) ☐ **Federal DOT Test** ☐ **Non – DOT Test**

Previous Test Results – List Type: Random, Reasonable Suspicion, Post-Accident, Follow-up, Pre-employment	**Date:**	**Results: (Negative or Positive & Substance)**

Supervisor's Comments (pertinent facts and history including attendance and behavior)

Status: ☐ **LWOP** ☐ **Suspension of _____ days, then eligible to use:** ☐ **Sick Leave (_____ days available, if known)**
☐ **Suspension Pending Evaluation** ☐ **Vacation Leave (_____ days available, if known)**

Beginning date of suspension, if applicable: _____ Ending date of suspension, if applicable: _____

Please complete and fax this form to us (at 808-597-8230) before the employee calls us so that we may schedule an appointment with them. If there is additional information you would like to provide us, please call us at 808-597-8222.

1221 Kapiolani Blvd. #730 Honolulu, Hawaii 96814 Tel: 808.597.8222 Fax: **808.597.8230**