TOWN OF CHAPEL HILL DRUG AND ALCOHOL FREE WORKPLACE SUPERVISOR'S GUIDE

PRE-EMPLOYMENT TESTING

Town Drug and Alcohol Free Workplace Procedures Section I-1
All employees and candidates who receive a conditional offer of employment are required to consent to testing for the use of drugs and/or alcohol.

Chapel Hill Transit Substance Abuse Policy Section J.
All applicants for covered FTA positions shall undergo urine drug testing prior to performance of a safety-sensitive function.

New Hires Notification and Scheduling of Test
After the hiring approval process has been completed the following process should be followed:

Supervisor

- ☐ Extend conditional job offer to candidate
- ☐ Inform candidate that they must take and drug test and pass a background check prior to starting employment
- ☐ Inform candidate they must contact HRD within 24 hours of the job offer (Chapel Hill Transit follows their own pre-employment testing procedures)
- ☐ Informs candidate that they must present a valid ID to HRD and the Testing Site (Chapel Hill Transit follows their own pre-employment testing procedures)
- ☐ If candidate refuses to take test inform them that they are no longer eligible for employment with the Town, and notify HRD.

HRD

- ☐ Schedule Testing
- ☐ Explain testing process and procedures
- ☐ Receive test result
- ☐ Inform department designee of test results

Note: **Out of Town Testing**
Candidates who live out of Town will be referred sites from the Nationwide Testing Association (NTA) referral list.

POST ACCIDENT

Town Drug and Alcohol Free Workplace Procedures Section I-4
Any employee who is involved in an accident with a Town vehicle or any other vehicle while on Town business or equipment, must immediately notify their management of the incident.

Chapel Hill Transit Substance Abuse Policy Section L.
All Covered employees will be required to undergo urine and breath testing if they are involved in an accident as defined by Section VI of the policy

POST ACCIDENT TESTING REQUIREMENTS FOR SAFETY SENSITIVE EMPLOYEES

TYPE OF ACCIDENT	CITATION ISSUED TO DRIVER	TESTING MUST BE PERFORMED	IF EMPLOYEE IS COVERED BY FTA
Human Fatality	Yes	Yes	Yes
	No	Yes	Yes
Bodily injury with immediate medical treatment away from the scene	Yes	Yes	**Yes,** unless driver is completely discounted as contributing factor
	No	No	**Yes**, unless driver is completely discounted as contributing factor
Disabling damage to any motor vehicle requiring tow away	Yes	Yes	**Yes,** unless driver is completely discounted as contributing factor
	No	No	**Yes,** unless driver is completely discounted as contributing factor

ANY TOWN EMPLOYEE MUST BE TESTED IF REASONABLE SUSPICION EXISTS

Supervisor

- ☐ Determine if employee requires medical attention
- ☐ Call Police if they have not been called
- ☐ Complete the Post Accident Decision Making Form (Copy Attached)
- ☐ Inform employee whether testing is required.
- ☐ If no testing is required and employee does not require medical attention direct employee to return to work
- ☐ If accident meets criteria for testing inform employee in private that testing is required and escort the employee to a Town authorized collection site
- ☐ If testing is required inform employee that he will be placed on administrative leave with pay pending the results of the testing
- ☐ Forward copy of the form to the department Safety Officer or designee

RANDOM TESTING

Town Drug and Alcohol Free Workplace Procedures Section I-2
All Safety Sensitive employees are subject to random testing for alcohol and drugs.

Chapel Hill Transit Substance Abuse Policy Section M.
All covered employees will be subjected to random, unannounced testing.

Department Designee

- ☐ Receives list (via email) of employees to be tested from NTA
- ☐ Notify supervisors
- ☐ Notify NTA when employee is unavailable
- ☐ Maintain supply of chain of custody forms
- ☐ Ensure employee is escorted to testing site.

Supervisor

- ☐ Transport the employee to the collection site.
- ☐ Keep the employee under observation until testing begins.
- ☐ If a positive test result is received, remove employee from duty immediately and consult with department head, HRD and Legal.
- ☐ If appropriate, consult with EAP

Department Head

- ☐ Contact HRD and Legal
- ☐ If test is positive, place employee on administrative leave
- ☐ Inform Town Manager

REASONABLE SUSPICION

Town Drug and Alcohol Free Workplace Procedures Section I-3
A reasonable suspicion alcohol and/or drug test may be required of any employee when the Town, acting through its supervisors and/or department heads has reason to believe or suspect that an individual's ability to safely and efficiently perform his/her job is impaired.

Chapel Hill Transit Substance Abuse Policy K.
All Town employees covered under this policy will be subject to a reasonable suspicion drug and/or alcohol test when the employer has reasonable suspicion to believe that the covered employee has used a prohibited drug and/or engaged in alcohol misuse.

Supervisor

- ☐ **Begin** to document the basis of your reasonable suspicion including Policy and/or safety precaution violation(s).
- ☐ Obtain assistance of the **Department Head** (or designee) or, if unavailable, another supervisor or manager or HRD to assist you during the fact-finding.
- ☐ Remove the employee from the work area.
  - ✓ **Do not** leave the employee unattended.
  - ✓ **Do ask** the employee to sit in a discreet location such as an office.
  - ✓ Ensure, however, that you do not isolate yourself in a location where you cannot be easily helped in case of an emergency.
- ☐ Keep the employee under observation until testing begins.
- ☐ Make sure that any evidence is safety stored.
- ☐ Meet with the employee
  - ✓ Hold the meeting in a private area.
  - ✓ Have a second certified individual in attendance (if possible).
  - ✓ If DOT employee and supervisor is not certified, must have second supervisor present.
  - ✓ Inform the employee of your concerns.
- ☐ Begin to use the **Incident Report Checklist for Reasonable Suspicion Testing** to note what you have seen, heard, smelled, touched, etc.
- ☐ Transport the employee to the collection site
- ☐ After testing, ensure that the employee is transported home (if employee's requests to be dropped off at another location make sure to note in your report.
- ☐ Maintain **confidentiality** by only discussing your suspicions with the department head or others assisting you in the fact-finding.

Department Head

- ☐ Contact HRD and Legal
- ☐ If test is positive, place employee on administrative
- ☐ Inform Town Manager

SELF ADMISSION

Town Drug and Alcohol Free Workplace Procedures Section F-2

Voluntary Admission Prior to Testing: Voluntary admission of a substance abuse problem by an employee prior to random, reasonable suspicion, or positive test result will be noted when considering, but does not exempt an employee from, disciplinary action.

Supervisor

- ☐ Immediately removed from safety-sensitive duties
- ☐ Contact Department Head, HRD or Legal to assist in the investigation
- ☐ Refer employee to EAP provider
- ☐ If the employee admits to abusing alcohol, inform employee that they will be placed on Family Medical leave until he/she has completed a rehabilitation program.
- ☐ If the employee admits to abusing drugs, inform the employee that they will be placed on administrative leave pending the outcome of the fact-finding (department head will determine if the leave is with or without pay)
- ☐ If the admission may result in a criminal investigation, read employee their Garrity Rights
- ☐ Provide employee with FMLA forms
- ☐ Provide employee with EAP/SAP Release Form (Copy Attached)
- ☐ Coordinate discussion with Supervisor and EAP/SAP

RETURN TO DUTY

Town Drug and Alcohol Free Workplace Procedures Section L-5

If continued employment is allowed, the employee is required to successfully complete a drug-abuse assistance program and a return-to-duty drug and alcohol testing, and agree to participate in follow-up testing for a period of at least (1) year as a condition of employment. The employee must be tested at least six times during that one year period.

Chapel Hill Transit Substance Abuse Policy Section N.

In the rare event an employee is reinstated with court order or other action beyond the control of the transit system, the employee must complete the return-to-duty process prior to the performance of safety-sensitive functions.

Supervisor

- ☐ Ensure that employee is available for all follow-up tests
- ☐ Provide chain of custody form to employee
- ☐ Maintain appropriate documentation and forms
- ☐ Escort employee to testing site
- ☐ If a positive test result is received, proceed with appropriate disciplinary action.

TOWN OF CHAPEL HILL
DEPARTMENT CONTACTS FOR RANDOM TESTING

DEPARTMENT	RANDOM TESTING NOTICES	RESULTS
FIRE	Fire Chief Deputy Fire Chief Training Chief	Fire Chief (Positive Only) Deputy Fire Chief Training Chief
HOUSING AND COMMUNITY SERVICES	Executive Director Director Operations and Special Project Coordinator	Director Operations and Special Project Coordinator
POLICE	Police Chief Assistant Chief Captain	Police Chief Assistant Chief Professional Standards Officer
PARKS AND RECREATION	Director Assistant Director Administrative Services Manager Superintendent	Director Assistant Director Administrative Services Manager Superintendent
PLANNING AND SUSTAINABILITY	Executive Supervisor Building Inspector Manager Chief Building Inspector	Executive Supervisor Building Inspector Manager Chief Building Inspector
PUBLIC WORKS	Director Occupational Health and Safety Coordinator Superintendent	Director Occupational Health and Safety Coordinator Superintendent
TRANSIT	Director Assistant Director Transit Safety Coordinator Administrative Services Manager	Director Assistant Director Transit Safety Coordinator Administrative Services Manager
HUMAN RESOURCE DEVELOPMENT	Director Assistant Director HRD Partner	Director Assistant Director HRD Partner

TOWN OF CHAPEL HILL
TESTING SITES

CONCENTRA 4104 Surles Court, Ste. 11 Durham, NC 27703	Phone: 919-941-1911 Fax: 919-941-1901	(Mon. - Fri.) 7:30am -7:30 pm (Weekends) 10am - 4pm
AFFORDABLE ON SITE	Phone: 919-620-0822	24 Hours
FAST MED (JULY 1, 2014) 1407 East Franklin St Chapel Hill, 27514 Durham 7010 Hope Valley Rd, Suite 101 Durham, 27707 38 sites throughout NC	Phone: 919-913-0996 Fax: 919-537-8577 Phone: 919-313-3900 Fax: 919-908-8420	Monday - Friday: 8 am - 8 pm | Saturday/Sunday: 8 am - 4 pm Holidays: 9 am - 4 pm

TOWN OF CHAPEL HILL
PRE-EMPLOYMENT DRUG TESTING
CONSENT AGREEMENT

As a condition of employment, I hereby agree to allow the Town of Chapel Hill to collect urine samples from me to determine the presence of illegal drugs in my body. Further, I give my consent to release my test results to an authorized Town representative for appropriate review, and authorize the Town to use the test results as a defense to any legal action to which I am party.

I understand that the results of the drug testing of my urine, if confirmed positive, will remove me from consideration for employment. I also understand that if I refuse to consent, I will be removed from further consideration of employment. Further, I understand that if employed by the Town, I must abide by the terms of the drug-free work place policy and may be required to submit to testing for the presence of illegal drugs or alcohol.

I understand that submission to such testing is a condition of employment with the Town of Chapel Hill, and the job offer may be rescinded if:

1. I refuse to consent to such testing;
2. I refuse to execute all forms of consent and releases of Liability as are usually and reasonably attendant to such examination;
3. I refuse to authorize release of the test results to the Town (if the tests establish a violation of the drug-free work place policy) or;
4. I do not report to provide the drug test specimen within 24 hours of the notification time stated on this form
5. I otherwise violate the policy.

I hereby understand the above conditions and agree to comply with them. I hereby give full consent to undergo a drug and/or alcohol test as a condition of employment with the Town of Chapel Hill.

Print Name Date

Signature Witness Date

FOR HRD USE ONLY

Date of Offer _____ Extended by _____

Department _____

Form of ID _____ Results Received _____

Chain of Custody Form Issued _____ Proof of Test Received _____

HRD Representative _____

TOWN OF CHAPEL HILL
POST-ACCIDENT DRUG AND ALCOHOL TESTING
DECISION MAKER FORM

This form is intended to assist you in determining if there is cause to test an employee after an accident.
Please refer to. Drug and Alcohol Free Workplace Procedures, Section I-4 for non FTA/FMCSA positions. Please refer to Chapel Hill Transit Drug and Alcohol Policy Section L for all FTA/FMCSA regulated positions.

ACCIDENT INFORMATION

Date of Accident _____ Time of Accident: _____ AM/PM

Employee Name: _____

Title: _____

DECISION QUESTIONS

1. Was there a human fatality? Yes ☐ No ☐ If *Yes,* Post-Accident tests are required.

If there was no fatality, ask the following questions:

2. Has any individual suffered a bodily injury and immediately received medical treatment away from the scene of the accident? Yes ☐ No ☐

3. Was there a disabling damage to the company vehicle or any other vehicle as a result of the occurrence and the vehicle was transported away from the scene by a tow truck or other vehicle? Yes ☐ No ☐

4. Was the driver issued a citation Yes ☐ No ☐

If you checked YES for question 1; or for questions 2 and 4; or for questions 3 and 4 , then post-accident tests are required unless you determine, using the best information available at the time of the decision, that the employee's performance can be **completely discounted** as a contributing factor to the accident. (Any reason for NOT conducting a Post-Accident test after you've answered YES to any of the above questions MUST be documented on the reverse side of this form.

Employee taken to _____ (Collection Site)

By _____

Title _____ _____ at _____AM/PM

Town Policy and FTA/FMCSA regulations also require that testing be done as soon as possible following the accident. If alcohol testing is not conducted within 2 hours after the accident, you must document the reason for the delay on the reverse side of this form. If the alcohol test is not administered within 8 hours, and the drug test within 32 hours, you must cease all efforts to administer the tests and document the reason(s) why the tests were not administered within the prescribed time frames.

Test Completed in accordance with the Policy Yes ☐ No ☐
If no, Reason Test Was Not Completed or Delayed:

_____

_____

_____

_____ _____
Signature of Supervisor/Manager Completing Form Date

SAMPLE CHAIN OF CUSTODY FORM (actual form may vary)

Laboratory Corporation of America Holdings

69 First Ave., Raritan, NJ 08869
1904 Alexander Dr., Research Triangle Park, NC 27709
1120 Main Street, Southaven, MS 38671
7207 North Gessner, Houston, TX 77040

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Printed: 07/11
3000
Customer Svc: 800-833-3984

0837885742

SPECIMEN ID NO. 0837885742 ACCESSION NO.

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.

TOWN OF CHAPEL HILL/FIRE DEPT.
ATTN: MIKE BECKMAN
405 MARTIN LUTHER KING JR.BLVD
CHAPEL HILL NC 27514
919-969-5035 Fx: 919-968-2839

B. MRO Name, Address, Phone No. and Fax No.

NTA
ATTN: DR. JEROME COOPER
P.O. BOX 508/772 N. BROAD ST.
MOORESVILLE NC 28115
800-452-0030 FAX: 704-658-1303

918126

C. Donor SSN or Employee I.D. No.

LOCATION CODE:

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)

F. Drug Tests to be Performed: ☒ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Phone No.

Collector Fax No.

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark | Collection: ☐ Split ☐ Single ☐ None Provided, Enter Remark | ☐ Observed, Enter Remark

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____
Signature of Collector

(PRINT) Collector's Name (First, MI, Last) | Date (Mo/Day/Yr) | Time of Collection AM PM

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service

RECEIVED AT LAB OR IITF:

X _____
Signature of Accessioner

(PRINT) Accessioner's Name (First, MI, Last) | Date (Mo/Day/Yr)

Primary Specimen Bottle Seal Intact ☐ YES ☐ NO
If NO, Enter remark in Step 5A.

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY

☐ **NEGATIVE** ☐ DILUTE ☐ **POSITIVE** for: ☐ Marijuana Metabolite (Δ9-THCA) ☐ Cocaine Metabolite (BZE) ☐ PCP ☐ 6-Acetylmorphine ☐ Morphine ☐ Codeine ☐ Methamphetamine ☐ Amphetamine ☐ MDMA ☐ MDA ☐ MDEA

☐ **REJECTED FOR TESTING** ☐ **ADULTERATED** ☐ **SUBSTITUTED** ☐ **INVALID RESULT**

REMARKS: _____

Test Facility (if different from above) : _____

I certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable Federal requirements.

X _____ _____ ____/____/____
Signature of Certifying Technician/Scientist | (PRINT) Certifying Technician/Scientist's Name (First, MI, Last) | Date (Mo/Day/Yr)

STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

_____
Laboratory Name

_____
Laboratory Address

☐ **RECONFIRMED** ☐ **FAILED TO RECONFIRM** - REASON _____

I certify that the split specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable Federal requirements.

X _____ _____ ____/____/____
Signature of Certifying Scientist | (PRINT) Certifying Scientist's Name (First, MI, Last) | Date (Mo./Day/Yr.)

CONTAINER SEAL

3000
0837885742

Bottle A
0837885742

Bottle B (SPLIT)
0837885742

A ____/____/____ _____
DATE DONOR'S INITIALS

B SPLIT ____/____/____ _____
DATE DONOR'S INITIALS

NOTE POSITIO OF BARCODE STARTS AT BOTTOM OF CONTAINER AS SHOWN HERE.

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

COPY 1 - TEST FACILITY COPY

TOWN OF CHAPEL HILL **REASONABLE SUSPICION** **LONG-TERM OBSERVATION CHECKLIST**			
Employee Name	**Job Title**	**Department**	**Division**
Supervisor Name	Title	Observation Period	

This checklist is intended to assist in evaluating an employee's performance over a period of time. This information may be used to support a reasonable suspicion drug test. Has the employee manifested any of the following behaviors? (**NOTE: If reasonable suspicion exists because of a specific incident, complete the Reasonable Suspicion Short-Term Observation Checklist).**

A. QUALITY AND QUANTITY OF WORK (CHECK ALL THAT APPLY) — **DOCUMENTATION AVAILABLE**

☐ Clear refusal to do assigned tasks	☐ Yes	☐ No
☐ Significant increase in errors	☐ Yes	☐ No
☐ Repeated errors in spite of increased guidance	☐ Yes	☐ No
☐ Reduced quantity of work	☐ Yes	☐ No
☐ Inconsistent, "up and down" quantity and quality of work	☐ Yes	☐ No
☐ Procrastination on significant tasks or decisions	☐ Yes	☐ No
☐ Frequent, unsupported explanations for poor work performance	☐ Yes	☐ No
☐ Other, please specify below:		

B. INTERPERSONAL WORK RELATIONSHIPS (CHECK ALL THAT APPLY)

☐ Significant change in relations with co-workers, supervisors, others	☐ Yes	☐ No
☐ Noticeable change in verbal or written communications	☐ Yes	☐ No
☐ Frequent or intense arguments	☐ Yes	☐ No
☐ Persistently withdrawn or less involved with people	☐ Yes	☐ No
☐ Intentional avoidance of supervisor	☐ Yes	☐ No
☐ Expressions of frustration or avoidance	☐ Yes	☐ No
☐ Change in frequency or nature of complaints	☐ Yes	☐ No
☐ Complaints by co-workers or subordinates	☐ Yes	☐ No
☐ Unusual sensitivity to advice or critique of work	☐ Yes	☐ No
☐ Unpredictable response to supervision	☐ Yes	☐ No
☐ Passive-aggressive attitude or behavior, doing things "behind your back"	☐ Yes	☐ No
☐ Other, please describe below:	☐ Yes	☐ No

TOWN OF CHAPEL HILL
REASONABLE SUSPICION
LONG-TERM OBSERVATION CHECKLIST CONTINUED

EMPLOYEE NAME

C. GENERAL JOB PERFORMANCE (CHECK ALL THAT APPLY)	**DOCUMENTATION AVIALABLE**	
☐ Excessive use of sick leave	☐ Yes	☐ No
☐ Frequent Monday/Friday/after holiday absences or similar pattern	☐ Yes	☐ No
☐ Frequent unexplained disappearances or trips to rest the room	☐ Yes	☐ No
☐ Excessive "extension" of breaks or lunch	☐ Yes	☐ No
☐ Frequently leaves work early	☐ Yes	☐ No
☐ Frequent personal phone calls	☐ Yes	☐ No
☐ Increased concern from others about, or instances of, safety violations	☐ Yes	☐ No
☐ Experiences, or causes, job accidents	☐ Yes	☐ No
☐ Interferes with or ignores established procedures	☐ Yes	☐ No
☐ Inability to follow through on performance recommendation	☐ Yes	☐ No
D. PERSONAL MATTERS (CHECK ALL THAT APPLY)		
☐ Changes in or unusual personal appearance (dress, hygiene)	☐ Yes	☐ No
☐ Changes in usual speech (incoherent, loud, stuttering or slurred)	☐ Yes	☐ No
☐ Changes in or unusual facial expressions, flushed or clammy face, bloodshot eyes	☐ Yes	☐ No
☐ Marked increased or reduced level of activity (fatigue, sleeping On the job, hyper activity)	☐ Yes	☐ No
☐ Increasingly irritable, tearful, excitable, nervous	☐ Yes	☐ No
☐ Persistently boisterous or rambunctious	☐ Yes	☐ No
☐ Unpredictable or out-of-control displays of emotions	☐ Yes	☐ No
☐ Engages in discussions about obtaining drugs or alcohol	☐ Yes	☐ No
☐ Makes unfounded accusations toward others (i.e. has feelings of Persecution or paranoia)		
☐ Secretive or furtive	☐ Yes	☐ No
☐ Memory problems (difficulty recalling instructions, data, past behavior)	☐ Yes	☐ No
Frequent colds, flu, or other illness	☐ Yes	☐ No
☐ Excessive fatigue	☐ Yes	☐ No
☐ Makes unreliable or false statements	☐ Yes	☐ No
☐ Makes unrealistic self-appraisal or grandiose statements	☐ Yes	☐ No
☐ Engages in temper tantrums or angry outbursts	☐ Yes	☐ No
☐ Demanding, rigid, inflexible	☐ Yes	☐ No
☐ Major changes in physical health	☐ Yes	☐ No

E. OTHER OBSERVATIONS (Attach additional sheets as needed)

_____

_____

_____

Supervisor Signature Date/Time

TOWN OF CHAPEL HILL
REASONABLE SUSPICION
SHORT-TERM OBSERVATION CHECKLIST

Employee Name	Job Title	Department	Division

Complete this checklist for any incident where reasonable suspicion exists that an employee is intoxicated, under the influence of, or otherwise shows signs of recent use of a prohibited drug or alcohol. Indicate all relevant behavior and physical symptoms of recent substance use. Check each item on this form and add any additional facts or conditions which you have observed. If there are long-term behavioral indicators of substance abuse which support this checklist, please also include the Reasonable Cause Drug Test Long-Term Observation Checklist.

A. NATURE OF INCIDENT

- ☐ Observed possession or use of an unknown substance or drug paraphernalia
- ☐ Apparent drug or alcohol intoxication
- ☐ Observed abnormal or erratic behavior consistent with drugs or alcohol
- ☐ Arrest or conviction for drug-related offense
- ☐ Other observations consistent with prohibited drug use or alcohol misuse (e.g., reports by passenger or reliable/credible third party, flagrant violation of safety or serious misconduct, fighting or argumentative/abusive language, refusal of supervisor instruction, unauthorized absence on the job). NOTE: PLEASE DESCRIBE BELOW

_____

_____

_____

B. BEHAVIORS OBSERVED (CHECK ALL THAT APPLY)

- ☐ Verbal abusiveness
- ☐ Physical abusiveness
- ☐ Extreme aggressiveness or agitation
- ☐ Withdrawal, depression, tearfulness, or unresponsiveness
- ☐ Other erratic or inappropriate behavior (e.g., hallucinations, disoriented, excessive euphoria, and talkativeness, confused) NOTE: PLEASE DESCRIBE BELOW:

_____

_____

F. PHYSICAL SYMPTOMS (CHECK ALL THAT APPLY)

- ☐ Slurred or incoherent speech
- ☐ Unsteady gait, loss of physical control, poor coordination
- ☐ Dilated or constricted pupils or unusual eye movement
- ☐ Extreme fatigue or sleeping on the job
- ☐ Nausea or vomiting
- ☐ Odor of marijuana
- ☐ Runny nose or sores around the nose
- ☐ Rapid, irregular, or difficulty breathing
- ☐ Disheveled appearance or out of uniform
- ☐ Shaking hands or body tremors/twitching
- ☐ Bloodshot or watery eyes
- ☐ Extreme excitement or nervousness
- ☐ Dizziness or fainting
- ☐ Odor of alcohol
- ☐ Dry mouth (frequent swallowing/lip wetting)
- ☐ Puncture marks or "tracks" over veins
- ☐ Other - PLEASE DESCRIBE BELOW:

_____

_____

_____

G. WRITTEN SUMMARY Please summarize the facts and circumstances of the incident, employee response, supervisor actions taken, and any other pertinent information not previously noted. Please note the date, time, and location(s) of the Reasonable Cause observation(s). Note if the employee REFUSED the test. Attach additional sheets as needed.

_____

_____

_____

Supervisors Signature Title Date/Time

_____

Witness Signature Title Date/Time

FRANK HORTON ASSOCIATES
EMPLOYEE ASSISTANCE PROGRAM

ATTENTION SUPERVISOR: Before meeting with an employee, the first step in making a successful EAP referral is to call Frank Horton Associates at 919-850-3410 or 1-800-326-3864. We will take you through the process of appropriately referring an employee to the EAP.

SUPERVISORY/MANAGEMENT REFERRAL
Release of Information

Name of Company: _____

Company Address: _____

I, _____, understand that I am being referred to
(*Name of Employee*)

Frank Horton Associates EAP due to _____

_____

_____

_____

I understand that I must contact Frank Horton Associates EAP at 919-850-3410 or 1-800-326-3864 within _____ days to schedule an appointment for an assessment.

I authorize Frank Horton Associates to release the following information to:

_____
Name of Referring Supervisor/Manager/HR Liaison (Please Print)

_____
Phone Number(s) *Email address*

Information to be released includes:

1. Scheduled appointments and attendance.
2. Compliance with recommendations.
3. Completion of treatment/education.

I understand that this referral is part of an effort to improve job performance and/or attendance. I further understand that my return to work (if applicable) depends on successful completion of the recommended treatment plan by Frank Horton Associates and compliance with all other requirements of my company's policies and procedures.

_____ _____
Signature (Employee) *(Print name)*

_____
Date signed by employee

_____ _____
Signature of Supervisor (Employer) *(Print name)*

_____
Date Signed by Supervisor (Employer)

ATTENTION SUPERVISOR:
PRIOR TO THE FIRST EAP VISIT, please fax this form to Frank Horton Associates at 919-850-9825 (Raleigh office) or 336-691-9542 (Greensboro office).