**Statement of Understanding**

for the release and exchange of information

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_acknowledge that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Employee) (Name of DOT Qualified SAP)

and the entities named below must disclose to each other and receive from each other pertinent and relevant information regarding:

1. Violation of DOT regulation
2. Drug and/or alcohol test results
3. Summary of the treatment plan
4. Evaluation and treatment recommendations
5. Treatment progress reports, including attendance and test results
6. Program completion information, including discharge summary
7. Other relevant information as it pertains to return-to-duty process

 EAP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Employee’s Initial)

 Treatment/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education Program (Name) (Employee’s Initial)

 DER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Employee’s Initial)

 MRO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Employee’s Initial)

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Employee’s Initial)

**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 communication between service agents/entities is required** under U.S. Department of Transportation rules and regulations, and is permitted without my authorization. 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. I understand that my written consent will be obtained prior to disclosing information to any entity other than those listed herein.

**I understand the fees for SAP Return to Duty services are for the following services**: initial evaluation, referral to independent provider(s), case management, compliance interview, initial report, compliance status report, and follow-up testing plan report to employer and potential future employers, as requested. I understand that I may be subject to follow-up testing for up to five (5) years. I understand my records will be held for five years.

**I understand it is my responsibility to allow ample time for the metabolizing of any illicit substance from my system and it is also my responsibility to know my company’s drug/alcohol testing policies and procedures.**

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_