

# Ohio Employee Assistance Program (OEAP)

## Participation Agreement for:

Employee Name (Last, First)

Name of Agency / Institution

<b>PARTICIPATION AGREEMENT KEY:</b>
<b>PARTICIPATION AGREEMENT which is THIS AGREEMENT</b>
<b>I / YOU / YOUR = Employee Name:</b>

Upon completion of this Participation Agreement, scan and email it to OEAP@das.ohio.gov or fax it to the OEAP office at 614-728-3046.

The **Ohio Employee Assistance Program (OEAP) PARTICIPATION AGREEMENT** is an agreement between a State of Ohio employee and his or her state agency that seeks to remediate a work rule violation by allowing the employee to complete an assistance program that is designed to treat a contributing personal problem. The Agreement may be in effect for a **minimum duration of 180 calendar days up to a maximum of 730 calendar days**. The PARTICIPATION AGREEMENT serves as documentation that the employee agrees to participate in a recognized program of treatment through an OEAP referral. A treatment plan is developed by a health care provider.

1. I agree to seek treatment from a health care provider under the OEAP PARTICIPATION AGREEMENT program. The duration of the Participation Agreement will be for (state specific rule violation):  
\_\_\_\_\_ day(s) to address the violation of: \_\_\_\_\_.
2. I agree to contact the assigned OEAP Consultant following the first session with the health care provider to provide information that I attended the initial session and the dates of any follow-up sessions.
3. I agree to maintain weekly telephone contact with the OEAP Consultant for the duration of the OEAP PARTICIPATION AGREEMENT program, or until otherwise notified.
4. I agree to refrain from further violation of the same work rules and agree not to commit the same or similar infraction(s) which led to this PARTICIPATION AGREEMENT.
5. I understand the agency will hold the proposed discipline in abeyance pending successful completion of all of the conditions in this PARTICIPATION AGREEMENT. The proposed discipline is:  
 \_\_\_\_\_  
*(Describe the details of the of discipline here – attach a separate sheet if necessary)*  
 See attached discipline document for description.
6. In the case of a positive alcohol/drug test result, YOU agree to execute a Last Chance Agreement in conformance with the terms of the Collective Bargaining Agreement and/or applicable law. YOU further agree to attend and complete a substance abuse program certified by the Department of Mental Health and Addiction Services, or a licensed Substance Abuse/Chemical Dependency provider approved by the OEAP program. Violation of the terms of the Last Change Agreement will result in termination.
7. Upon successful completion of the PARTICIPATION AGREEMENT, the agency may do the following:  
 Dismiss the pending discipline;  
 Reduce the discipline to \_\_\_\_\_ (state reduced level);  
 Recommend leniency to the appointing authority at the completion of the PARTICIPATION AGREEMENT, provided job performance is satisfactory. It is understood that this recommendation will likely result in a reduced or dismissed discipline, though not in every case; and  
 In the case of an alcohol/drug positive test result, honor the terms of your Last Chance Agreement.

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8. **UNIVERSAL CONSENT FOR RELEASE OF INFORMATION:** By signing this agreement, I agree to give all necessary consent, including authorization for release of information necessary to execute this PARTICIPATION AGREEMENT, for the duration of the PARTICIPATION AGREEMENT. My consent is limited to the following:

- a) Notifying the agency regarding my compliance or non-compliance with the PARTICIPATION AGREEMENT and general progress;
- b) Providing information from my health care provider to OEAP to include: diagnosis, prognosis, plan of treatment, treatment compliance and attendance at scheduled appointments; and
- c) In the case of alcohol/drug test results, authorizing the agency and OEAP to receive information from the Ohio Department of Administrative Services; Office of Drug Free Workplace and to correspond with them regarding alcohol/drug test results. This will be necessary to monitor your participation and compliance with the terms of your PARTICIPATION AGREEMENT and Last Chance Agreement.

9. **RELEASE OF INFORMATION TO EMPLOYER REPRESENTATIVE:** I authorize the following employer representative(s) to receive notice of my compliance or non-compliance with my PARTICIPATION AGREEMENT.

Primary Contact \_\_\_\_\_ Phone # \_\_\_\_\_  
(First Name) (Last Name) \_\_\_\_\_ (initials)

Secondary Contact \_\_\_\_\_ Phone # \_\_\_\_\_  
(First Name) (Last Name) \_\_\_\_\_ (initials)

10. **OPTIONAL RELEASE OF INFORMATION TO UNION REPRESENTATIVE:** I authorize my Union representative(s) to receive notice of my compliance or non-compliance with my Participation Agreement.

\_\_\_\_\_ Phone# \_\_\_\_\_  
(First Name) (Last Name) \_\_\_\_\_ (initials)

**CONFIDENTIALITY:** OEAP will NOT disclose records of identity, diagnosis, prognosis, or treatment that are maintained in connection with your participation in the Ohio Employee Assistance Program unless: you have authorized or consented to such disclosure; to meet a bona fide medical emergency; or, as otherwise required by federal or state laws. **I have carefully reviewed this PARTICIPATION AGREEMENT and knowingly and voluntarily enter into this agreement, and hereby give consent and authorization for the release of information as indicated in this PARTICIPATION AGREEMENT.**

\_\_\_\_\_  
SIGNATURE Print Name of Employee DATE

\_\_\_\_\_  
SIGNATURE Print Name of HR designee duly authorized DATE

\_\_\_\_\_  
SIGNATURE Print Name of Union designee duly authorized DATE

### Completion Instructions:

- Print this agreement and ensure that all parties sign and date in the designated spaces; and
- Scan and send this agreement via email to [OEAP@das.ohio.gov](mailto:OEAP@das.ohio.gov) or fax it to the OEAP Office at 614-728-3046.