

**Ohio Employee Assistance Program (OEAP)
Substance Abuse Professional (SAP)/Chemical Dependency Provider (CDP) Certification
Return to Work**

I _____ (SAP/CDP) certify that I have assessed _____
for alcohol and/or other drug abuse (Employee) following a positive alcohol or other drug test. The initial assessment
was completed on _____. It does not appear, at this time, that the employee's condition
(Date)
will prevent the employee from performing his or her job duties.

**At a minimum, the employee's failure of the drug test will require at least one education session in addition to the
initial assessment. The employee must complete this education session prior to returning to work. The employee
completed the education session on _____.**
(Date)

In addition to the minimum education session:

- I do NOT recommend additional treatment and/or education.
- I recommend the following additional treatment and/or education:

- The additional treatment and/or education do NOT have to be completed prior to the employee's return to
work.
- The additional treatment and/or education session must be completed prior to the employees returning to
work, and was completed on _____.
(Date)

The referral to treatment and/or education shall be arranged by the SAP/CDP. When requested, an OEAP Consultant
may assist in this process after being notified by the SAP/ CDP.

**Note: An employee who tests positive under the State of Ohio's drug testing procedures are subject to a State
Sanctioned Return to Work (RTW) drug screen. The OEAP recommends that the employee obtain a pre-RTW drug
screen, prior to the official RTW test.**

The cut off levels are established by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is
part of the U.S. Department of Health and Human Services (DHHS) and/or as addressed in Ohio Revised Code (ORC)
123:1-76-06.

In addition to the required six follow up tests, which is at the employee's expense, during the next 12 months, I
recommend _____ additional test during this same time period. I certify that _____
(Employee)
may return to work on or after _____.
(Date)

**Substance Abuse Professional/Chemical Dependency
Provider Signature**

(-Date)

(License #)