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, which:
  - ☐ Does not have to be completed prior to the employee's return to work; or
  - ☐ Must be completed prior to the employee's return to work, please indicate the completion 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: Employees who test 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 are at the employee's expense, during the next 12 months, I recommend _____ additional test during this same time period.

_____ _____

Substance Abuse Professional/Chemical Dependency **(Date)**
Provider Signature

_____
(License #)