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EAP SUPERVISORY REFERRAL FORM

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee's poor work performance when there is reason to believe that the cause may be due to a personal/medical problem. Additionally, please note that the EAP vendor will inform the State's EAP Coordinator of each instance where an employee attends and fails to attend a scheduled EAP counseling session. **THIS FORM AND ALL SUPPORTING DOCUMENTATION MUST BE SUBMITTED TO THE EAP IN DUPLICATE. IF DOCUMENTATION DOES NOT EXIST, PLEASE PROVIDE A SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL. DO NOT SUBMIT WITHOUT ONE OR THE OTHER**.

(Please print in ink, or type) REFERRAL DATE: _______________

EMPLOYEE'S NAME: ________________________________ GENDER: ________

(Please circle: Mr./Mrs./Ms.)

ADDRESS: ____

(City/County, State, Zip Code)

HOME PH.: _______________ WK.PH.: _______________ CELL PH.: _______________

CLASSIFICATION: ____________________________________

GRADE: _________ EOD: ______________ DOB: ____________ MARITAL STATUS: ___________________

DEPARTMENT/AGENCY NAME: ____

WORK ADDRESS: ____

(City/County, State, Zip Code)

WORK HOURS/SHIFT: ___________________________ DAYS OFF: _________________

(Please use ***non*-military** time)

REFERRED BY: ___________________________ TITLE: ___________________________

PHONE: _________________________________ FAX: ____________________________

AGENCY EAP REPRESENTATIVE: ______________________________ PH._______________

TITLE: ___________________________________ FAX: _________________________

____

(Agency EAP Representative's Signature)

MAILING ADDRESS: ____

____

____

REASON FOR REFERRAL

***First*, check off which type of referral this is. *Next*, check off the corresponding areas that are relevant to this referral; *then* attach documentation or synopsis supporting areas checked and overall reason for this referral. This is a:**

I. ☐ **SUBSTANCE ABUSE REFERRAL**

VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE:

_______Failed random drug test __________ Alcohol related conviction

_______Other____

II. ☐ **MENTAL HEALTH REFERRAL**

ATTENDANCE *(Please place numbers where numbers are requested)*:

______ Number of days absent past 12 mos. _____ Number of extended lunches past 6 mos.

______ Pattern (e.g., Mondays, Fridays, after paydays, before and after holidays) _____ Number of times late past 6 mos.

_____ Other________________________

____

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JOB PERFORMANCE: (This area *must* be impacted for referral eligibility, with supporting documentation attached for items checked):

________Lower quality of work ________Failure to meet schedules
________Decreased productivity ________Inability to concentrate
________Increased errors ________Other ____________________________________
________Impaired judgment/memory ____________________________________
________Erratic work patterns ____________________________________
____

BEHAVIOR DEMONSTRATED WITH RESPECT TO JOB PERFORMANCE:

________Avoids supervisors/coworkers ________Disregard for safety
________Less communicative ________Other_______________________
________Unusually sensitive to advice/constructive criticism _______________________
________Unusually critical of supervisor/coworkers/employer _______________________
________Loss of interest _______________________
________Frequent mood swings _______________________

DOMESTIC VIOLENCE: _____

Have the above issues been discussed with employee? (Yes) ____ (No) ____

Has employee been referred to State Medical Director? (Yes) ____ (No) ____

If yes, when? (Please attach relevant documents) ____________________________________

IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL CANNOT BE PROCESSED WITHOUT "YES" INDICATED BELOW AND EMPLOYEE'S SIGNATURE

I understand that my employer is referring me to the State Employee Assistance Program. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein and that I consent to and authorize the EAP vendor to release my attendance or lack thereof to the State. I understand this consent becomes effective on the date I sign it, and will continue in effect for the duration of the contract term between the State Employee Assistance Program and EAP Vendor. I agree to release the above named individual(s) or organization(s) and the EAP, the EAP counselor, and his/her designee from liability that may result from furnishing this information as authorized in this disclosure.

_______ YES, I will participate in the Employee Assistance Program. My health insurance carrier is:

____

________ NO, I will not participate in the Employee Assistance program.

____ ____________________________________
Signature Date

Your agency EAP Representative should forward this form and all supporting documentation *IN DUPLICATE* to:

Maryland Department of Budget and Management
Employee Relations Division
Employee Assistance Program
301 W. Preston Street, Room 607
Baltimore, Maryland 21201

or Fax to: 410-333-7603

If you have questions, please contact the Employee Assistance Program at 410-767-5846.

FAILURE TO LEGIBLY AND FULLY COMPLETE THIS FORM WILL RESULT IN APPOINTMENT DELAY

Providing your social security number will help us verify your identity. If you do not provide this information, your referral will still be processed. Your SSN will be kept confidential in accordance with federal and State laws and regulations and the Maryland Public Information Act (SG 10-624c).