Lisa Annulis, LCSW-C, SAP, SAE
1680 East Gude Drive Suite #311
Rockville, MD 20850
(301) 233-5721
saphelp@verizon.net
practiceguardian.com

INSTRUCTIONS FOR YOUR DOT SAP APPOINTMENT

Welcome to the office of Lisa Annulis, LCSW-C, SAP, SAE. Please follow the instructions for your appointment:

1. When you come into the building, come up the stairs and to the right are bathrooms. The waiting area right outside the bathrooms are the black and white chairs and tables. Don't follow the signs to suite #311.

2. If you are completing paperwork **at the office** come in 15 minutes early for your appointment. Look for a clip board on one of the black and white chairs with your initials on it. Complete the paperwork and I will come out to get you at the time discussed.

3. If you are completing the paperwork **prior to our appointment,** please bring all forms with you and have a seat in the black and white chairs as noted above. I will come out to get you at the discussed time.

PLEASE DO NOT KNOCK ON THE DOOR TO MY OFFICE WITH MY NAME ON IT. THE OFFICE IS A ONE ROOM SUITE.

4. The forms include

    a. INTAKE FORM Page 2
    Complete all information that applies to your situation. If you are unsure leave it blank. If you want me to communicate with a Designated Employer Representative (DER), I need all company information including a phone, fax and email for the contact.

    b. STATEMENTY OF UNDERSTANDING Page 3-4
    Please read carefully and complete all information that applies.

    c. DRUG/ALCOHOL SCREENING TOOL Page 5-6
    Answer the questions the best you can and leave blank any questions you are unclear about. We can discuss these questions when we meet.

INTAKE FORM

Referral Source and Date: MRO Info.:

Name of Company: Date Infraction:

Company Address: Substance:

Company (DER): Type of Test:

Contact Ph/Fax/Email: DOB:

Name: SS# (required):

Address: CDL#:

Phone/Email:

Results of D/A Screening Tool:

Do not write below the line Payment if Applicable:

Schooling:

Work History/CDL:

Substances:

Incident:

Legal/Consequences/Treatment:

- Legal Hx Verified?

Medical/Mental Health/Meds/Hospitalizations:

Leisure/Family History:

STATEMENT OF UNDERSTANDING FOR A DOT-COVERED EMPLOYEE WITH A DOT RULE VIOLATION

Your employer, and its employees in DOT-defined safety sensitive positions, is required to be in compliance with the Department of Transportation (DOT) drug and alcohol testing program. A rule violation means that you have had a positive test for drugs/alcohol, have refused a test or have disclosed prohibited use. If you have had a DOT Rule Violation, the regulations require that you stop duty immediately, see a SAP (Substance Abuse Professional) for a face-to-face assessment and comply with the treatment requirements set forth by the SAP.

I will meet with you initially to determine what actions you need to take to your address your DOT rule violation. As your SAP, I am required to make a recommendation for an intervention and provide a referral to, at a minimum, education, 12-step meetings, online substance abuse education. Other recommendations include substance abuse counseling sessions, substance abuse classes and higher levels of substance abuse treatment including Intensive Outpatient Treatment and Partial Hospitalization (PHP) and inpatient treatment. The cost of the SAP assessment is separate from the cost of recommendations. **I require payment in full for your SAP assessment, in cash or credit card subject to a 4% fee at the time of your initial assessment appointment.**

The law requires that I refer you to the best treatment/education available and when possible and appropriate, in your insurance network if you have insurance. However, there is no guarantee or requirement that my recommendation will be covered by your medical plan, and the law does not require my recommendation to be covered by your insurance. In addition, an employer's policy or labor agreement cannot make this requirement. It is your responsibility to determine whether or not outside services are covered under any such plan. It is also your responsibility to pay any charges not covered.

You will need to follow through with my referral before you can be considered for return to any DOT safety sensitive duty. This is an official DOT SAP evaluation and my recommendation cannot be changed by anyone else. I expect you to follow through with this referral within the next _____. If you have not followed through, I may report this to your employer as non-compliance. I will send a report of compliance when you follow my recommendation. If more than 30 days go by without initiation of the recommendation, I may require a reassessment at an additional fee of $_____,

This federal law prohibits you from seeking a second opinion from a different SAP. I am the SAP for this violation, and you can't look for another SAP, regardless of how long you delay the process. Do not lose my contact information.

I will be following your progress throughout your course of treatment. The length of treatment will be determined by your level of participation and progress. I will decide when it is appropriate to meet with you again for another face-to-face meeting, to determine whether you have successfully complied with my recommendations. I will then prepare a Follow-up Evaluation Report of Compliance, which I will send to your employer, who can decide whether to order a DOT Return to Duty test. You will be subject to additional DOT follow up testing for at least 12 months, but possibly up to 5 years. If you are working for any other DOT-covered employers at this time, you are required to notify them that you have a violation of Compliance, you are not permitted to operate a Commercial Motor Vehicle. You are also not permitted to apply for another job with any other DOT-covered employer.

LIMITS OF CONFIDENTIALITY

The following information about you may be communicated **without** a signed release:

- I will communicate with the Collector, Medical Review Officer (MRO) and education and/or treatment program personnel.
- I will communicate information about your compliance with the assessment and the recommendation process to your Designated Employer Representative (DER) or designated contact _____. Following your assessment, I will send an initial report to your DER/Contact outlining my recommendations. Following my follow-up evaluation, I will send a report of compliance (or non-compliance) to your DER.
- On request, I must make case records available to DOT agency representatives (e.g., inspectors conducting an audit or safety investigations) and representatives of the National Transportation Safety Board in an accident investigation.

A Release of Information is never required:

1. if there is a reasonable basis to suspect child or elder abuse and/or neglect; and to the extent required by state or federal law.

2. if, in my clinical judgment, you pose a serious danger to yourself or others.

Confidentiality laws prohibit me from sending any information about you to a new employer. If you seek employment with another DOT-covered employer, you must authorize me in writing to provide copies of these reports and your follow-up testing plan directly to that employer. **There will be an additional fee of $20.00 per transaction.**

CERTIFICATION

I certify that I have read and accept this Statement of Understanding.

I understand that I have a right to receive a copy of this authorization and that upon request, my SAP will provide me with a copy.

_____ _____
Signature of Employee Date

_____
Please Print Your Name

_____ _____
Witness (SAP) Date

_____

Please Print Your Name

DRUG/ALCOHOL SCREENING TOOL

Adapted from the Michigan Alcoholism Screening Test

DIRECTIONS: If a statement is true about you, put a check ( ) in the nearby space under YES. If a statement says something not true about you, put a check in the nearby space under NO. Please answer all of the questions and put your name and signature at the end.

	YES	**NO**
1. Do you consider your drug/alcohol behavior normal?	____	____
2. Do you ever experience memory loss or convulsions the day after heavy drug/alcohol use?	____	___
3. Does your spouse (or parents) ever worry or complain about your drug/alcohol use?	____	____
4. Can you stop using drugs/alcohol without a struggle once you have begun?	____	____
5. Do you ever feel bad about your drug/alcohol use?	____	____
6. Do friends or relatives think that your drug/alcohol use is normal?	____	____
7. Are you always able to stop using drugs/alcohol when you want to?	____	____
8. Have you ever gone to Alcoholics Anonymous or Narcotics Anonymous, or other self-help groups for your drug/alcohol use?	____	____
9. Have you ever gotten into fights while using drugs or alcohol?	____	____
10. Has drug/alcohol use ever created problems with you and your spouse (or parents)?	____	____
11. Has your spouse (or family member) ever gone to anyone for help about your drug/alcohol use?	____	____
12. Have you ever lost friends, or girlfriends or boyfriends because of your drug/alcohol use?	____	____
13. Have you ever gotten into trouble at school or at work because of your drug/alcohol use?	____	____

	YES	NO
14. Have you ever lost a job (or been suspended or expelled from school) because of your drug/alcohol use?	____	____
15. Have you ever neglected your obligations, family, and work or school for two or more days in a row because you were using drugs/alcohol?	____	____
16. Do you ever use drugs/alcohol before noon?	____	____
17. Have you ever been told that you have liver trouble?	____	____
18. Have you ever had seizures, severe shaking, heard voices, seen things that were not there or felt out of control and panicky after heavy drug/alcohol use?	____	____
19. Have you ever gone to anyone for help about your drug/alcohol use?	____	____
20. Have you ever gone to a hospital because of your drug/alcohol use?	____	____
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward, or a general hospital where drug/alcohol use was part of the problem?	____	____
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker or clergyman for help with an emotional problem in which drug/alcohol use played a part?	____	____
23. Have you ever been arrested (even for a few hours) because of behavior related to your drug/alcohol use?	____	____
24. Have you ever been arrested for driving while intoxicated?	____	____

Name of Client **Date**

Signature of Client **Date**