RADEP

Reckless and Aggressive Driver Education Program

ENROLLMENT FORM

NAME _____

LAST FIRST MI SUFFIX

MAILING ADDRESS _____

STREET

_____

COUNTY/CITY STATE ZIP

CELL PHONE ( ) _____ HOME PHONE ( ) _____

DATE OF BIRTH: _____ DRIVERS LICENSE NUMBER: _____

EMAIL ADDRESS: _____@_____

REFERRAL INFORMATION:

COURT JURISDICTION: _____

GENERAL DISTRICT COURT OR CIRCUIT COURT

DATE OF OFFENSE: _____

ORIGINAL COURT DATE: _____

RETURN COURT DATE: _____

I ATTEST THAT ALL INFORMATION LISTED ABOVE TO THE BE TRUE AND ACCURATE.

_____ _____

PARTICIPANT SIGNATURE DATE

PARTICIPATION AGREEMENT FOR RECKLESS AND AGGRESSIVE DRIVING PROGRAM

I understand that participation requirements are as follow:

1. I must pre-register for the program and pay the $125.00 fee.
2. All fees must be paid by money order, VISA, Discover or MasterCard
3. I must be on time and attend all assigned sessions.
4. I understand that I will be dismissed from class if I am texting or using my cell phone or any electronic device during class.
5. I must be alcohol and drug free while in the program.
6. I understand if I am disruptive in class I will be required to leave the session and will not receive credit.
7. I understand that fees are non-refundable.
8. I understand that due to the nature of the education materials presented, all classes must be taken in order and no absences are permitted.
9. I understand in the event that I am absent from a session, I will not receive class credit and all fees are non-refundable.
10. I understand that a certificate of completion will be provided to me upon completion of **all** required sessions and that it is my responsibility to provide the certificate to the Court prior to my return to court date.

_____

PARTICIPANT PRINTED NAME

_____ _____

PARTICIPANT SIGNATURE DATE

VIRGINIA ALCOHOL SAFETY ACTION PROGRAM EMAIL AUTHORIZATION

I understand that due to the risk of electronic messages being misdirected, hacked or intercepted by unintended parties, the Virginia Alcohol Safety Action Program (VASAP) cannot guarantee that confidential messages sent over the Internet will not be subject to unintended disclosure or other privacy breaches.

I understand that emails to/from VASAP may contain personnel information that is protected by federal confidentiality guidelines.

I further understand that emails sent to/from work devices may be subject to review by my employer.

Acknowledging the above, I hereby authorize the Virginia Alcohol Safety Action Program to communicate with me via email regarding my case until such time as my ASAP case is closed, or this authorization is rescinded by me.

_____

PARTICIPANT PRINTED NAME

_____ _____

PARTICIPANT SIGNATURE DATE

_____

EMAIL ADDRESS

VASAP CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION - GENERAL

Probationer: _____ **Date of Birth:** _____
(Nombre) (Fecha de nacimiento)

I hereby grant the Virginia Alcohol Safety Action Program (VASAP) consent to exchange information with:

- the court of record/referral
- the Commonwealth Attorney's office
- attorney(s) of record
- local, state and federal law enforcement agencies
- other criminal justice entities
- the Virginia Department of Motor Vehicles
- applicable VASAP ignition interlock service providers
- other (specify) _____

for the purpose of facilitating, supervising, verifying, and reporting my participation in, and compliance with ASAP requirements.

I understand that if I am being referred to the Alcohol Safety Action Program **by a court,** information concerning my participation will be reported to the court, and my consent for that purpose will terminate upon successful completion of my ASAP probation. In the event of noncompliance, this Consent for Release of Confidential Information will not expire until the referring court formally terminates the Alcohol Safety Action Program's oversight of the case.

I understand that if I am enrolling in the Alcohol Safety Action Program to complete a **DMV requirement,** this Consent for the Release of Confidential Information shall expire automatically upon termination of my ASAP participation.

I understand that my records are protected under Federal Confidentiality Regulations (42CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I further understand that all treatment information is protected under HIPAA and cannot be released by the ASAP without my consent; however, should I elect to transfer to another ASAP, all records to include treatment records will be sent to the supervising ASAP in order to effectively administer my case. A copy of this Consent for Release of Confidential Information form shall be considered to be valid as the original.

Executed this _____ **day of** _____, **20**_____
(dia) (mes) (año)

Participant's Signature: _____
(firma)

Parent/Guardian Signature (*required if under the age of 18*): _____

To revoke consent for release of information, complete this section.

Date Revoked: _____

Participant's Signature: _____

Parent/Guardian Signature *(if required)*: _____

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. **[Updated 8/23/19]**