



Proof of Assessment Form

Purpose of this form: This form is to document that a licensed professional has completed a substance use disorder assessment following an employee/applicant's positive or refusal workplace drug or alcohol test.

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|---------------------------|----------------------------|--------------------------|
| Employee/Applicant's Name | Employee Unique Identifier | Date of Positive/Refusal |
|---------------------------|----------------------------|--------------------------|

The employee/applicant contacting you either tested positive or refused on a workplace drug or alcohol test required under the Sound Transit Drug Free Card Program and is required to complete a substance use disorder assessment. If the employee/applicant tested positive on an alcohol test, they have been provided a copy of their test result to share with you. If they tested positive on a drug test, please contact the Medical Review Officer at 866-448-0651 for laboratory result details.

Please discuss any education or treatment recommendations directly with the employee/applicant. The employee/applicant's completion of any recommendations are not a requirement for the professional performing the assessment to complete this form.

The licensed professional performing the assessment must meet with the employee/applicant in person or using a legal form of telehealth in their state of practice.

Licensed Professional Credentials

(Mark your credentials from the list below and submit a copy of your credentials with this form)

- | | |
|---|---|
| <input type="checkbox"/> Licensed physician (Doctor of Medicine or Osteopathy) | <input type="checkbox"/> Alcohol and drug abuse counselor certified by one of the following: |
| <input type="checkbox"/> Licensed or certified social worker | ○ National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NAADAC) |
| <input type="checkbox"/> Licensed or certified psychologist | ○ International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC) |
| <input type="checkbox"/> Licensed or certified employee assistance professional | ○ National Board of Certified Counselors, Inc. and Affiliates/Master Addictions Counselor (NBCC). |
| <input type="checkbox"/> Licensed or certified marriage and family therapist | |

By signing this form, I certify that I am a licensed professional with the credentials marked above, I've provided a copy of my credentials with this form, and that I have personally completed a substance use disorder assessment on the above named employee/applicant, reviewed their positive drug and/or alcohol test results if applicable, and personally discussed the assessment results and any recommendations for education or treatment with the employee/applicant.

| | | |
|-----------------------|--------------------|-------|
| Provider Printed Name | Provider Signature | Date |
| Phone | Fax | Email |
| Address | | |

If you have any questions, call Drug Free Business at 866-448-0651. Scan and email the completed form and a copy of your credentials to mro@drugfreebusiness.org or fax to 425-489-0832.