Employee Assistance

Behavioral Health Programs

& ASSOCIATES, INC.

SUPERVISORY REFERRAL FORMS

REFERRAL TO THE GUP & ASSOCIATES EMPLOYEE ASSISTANCE PROGRAM

Date: _____ Referral: _____

To: _____ From: _____

This memo is to notify you that you are being referred to the GUP & ASSOCIATES Employee Assistance Program for any help you might need in addressing any problem(s) that may be affecting your recent job performance/work behavior/ policy violation. The work performance/attendance problem(s) listed below are of concern to me.

____ Job Performance Concern

- ____ Decrease in productivity
- ____ Attendance/tardiness problems
- ____ Accident during work hours
- ____ Interruption of the work performance of co-workers
- ____ Other _____

  _____

____ Policy Violation

- ____ Harassment Policy
- ____ Workplace aggression/violence policy
- ____ Substance abuse policy
- ____ Personal conduct policy
- ____ Other _____

  _____

The above-mentioned issue(s) have caused me sufficient concern to make this referral. It is my expectation that the above-mentioned job performance/concerns/policy violations will be resolved.

GUP & ASSOCIATES may assist you in addressing any problems that may be affecting your work or your personal life. This referral is a result of the company's concern for you as an employee and as a person. The company does not view this referral to GUP & ASSOCIATES as punishment, nor is it meant to be punitive in any manner. Rather, it is an opportunity for you to get assistance dealing with any personal concerns that may be interfering with your ability to meet expected job performance responsibilities.

OPTIONAL – CHECK IF APPLICABLE

Your attendance and compliance with GUP & ASSOCIATES recommendations may have an impact on your employment status, as indicated below.

____ Your employment status is dependant on your compliance with attendance and treatment recommendations made by GUP & ASSOCIATES. If you do not comply your employment may be terminated.

____ Your employment status is not dependant on your compliance with attendance compliance or treatment recommendations made by GUP & ASSOCIATES. However, if you do not comply, you may not be given another opportunity to use GUP & ASSOCIATES's services as part of a corrective action plan. Future corrective action measures regarding this job concern will be based on job performance, work behavior and policy compliance only.

____ It has not been determined if your employment is dependant on your attendance at counseling or compliance with GUP & ASSOCIATES's recommendations. If you do not comply with GUP & ASSOCIATES's attendance and treatment recommendations, you may not be given another opportunity to use GUP & ASSOCIATES's services as part of a corrective action plan. Future corrective action measures regarding this job concern will be based on job performance, work behavior and policy compliance only.

____ Other _____

_____

_____

_____

I urge you to take advantage of the services offered by GUP & ASSOCIATES. The only information that will be shared by GUP & ASSOCIATES with Human Resources is the information that you authorize GUP & ASSOCIATES to disclose. The following page details this information.

Please call GUP & ASSOCIATES within 48 hours. Whether you choose to contact GUP & ASSOCIATES is your choice. However, failure to call within 48 hours will be considered non-compliance with this formal referral and the above-indicated impact on your job status may apply.

GUP & ASSOCIATES EMPLOYEE ASSISTANCE PROGRAM

1-877-GUP-3200 OR 404-634-0014

I will follow up with you on to review your job performance/work behavior. If the previously-mentioned problem(s) have not been resolved within a reasonable period of time, further action may be taken.

The above information has been reviewed with me.

Witness _____ Employee's signature _____

Date _____ Date _____

CLIENT INFORMATION RELEASE AUTHORIZATION

I, _____ hereby authorize GUP & ASSOCIATES to release information obtained during my involvement with the Employee Assistance Program to the following individual(s)/organization and only under the conditions listed below:

1. Name and title of person and organization to whom disclosure of client information is to be made:

Name/Title _____

Organization _____

2. Specific type of information to be disclosed:

____ Attendance ____ Treatment Recommendations

____ Progress ____ Prognosis

Other: ____ Contact with GUP & ASSOCIATES/provider re: seeking counseling.

____ Availability for work; time off needed for treatment.

____ Compliance with treatment recommendations.

3. The purpose or need for such disclosure:

____ Job Stability ____ Comprehensive Treatment ____ Family Involvement

____ Legal ____ To Facilitate a Referral ____ Aftercare

____ Other (Be specific) _____

4. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon:

____ A. Date _____

____ B. Event: 120 days after case has been closed.

____ C. Condition _____

Witness _____ Employee's signature _____

Date _____ Date _____

Fill out this form electronically or by hand and EMAIL to drgup@gupinc.com