

REHABILITATION AGREEMENT

NAME (PRINT) _____

On _____, 20____, the Gallipolis City School District, as a condition of my continued employment, required that I seek evaluation and rehabilitation/ treatment from a substance abuse professional for alcohol and/or drug abuse. The following conditions apply:

1. I authorize my rehabilitation/treatment provider to submit to a designee of the Gallipolis City School District on at least a quarterly basis proof of my enrollment in and attendance at a rehabilitation/treatment program. I understand that my attendance will be monitored closely and that the Gallipolis City School District may institute disciplinary procedures, up to and including termination, if I do not attend all sessions and comply with all rehabilitation/treatment recommended by the substance abuse professional.
2. I must adhere to all recommendations and requirements of the drug/alcohol rehabilitation/treatment program in which I am enrolled.
3. I shall pay for all costs of evaluation and rehabilitation/treatment not covered under the Gallipolis City School District's medical benefits plan.
4. Upon completion of the rehabilitation/treatment program I understand that I will be required to supply the Gallipolis City School District with a statement from my rehabilitation/treatment provider that I have completed the program satisfactorily.
5. During the rehabilitation/treatment period and the twelve month period following completion of the rehabilitation I agree to submit to random testing for the illegal use of drugs and alcohol.
6. I must meet all requirements to be returned to safety-sensitive duties as outlined in Board Regulation EEACD-R "Enforcement and consequences for Violation" and as required by Federal law and regulations. The Gallipolis City School District may discipline me, up to and including termination, if I fail to meet all requirements for return to duty to a safety sensitive position as outlined in EEACD-R and in Federal law regulations.
7. I understand that I am subject to discipline, up to and including termination, if I fail to meet all requirements as outlined in EEACD and EEACD-R and in Federal law and regulations to return to duty in a safety-sensitive position.

I hereby voluntarily agree to all the above conditions and authorize my rehabilitation/treatment provider to provide the Gallipolis City School District with proof of my enrollment and attendance at the recommended rehabilitation/treatment program. I sign this rehabilitation agreement of my own free will and without duress.

Employee's Name

Supervisor's Name

Employee's Signature

Supervisor's Signature

Date

Date

[Adoption date: November 20, 1995]

Revised: July 17, 1996