Reasonable Suspicion Drug and Alcohol Training for Supervisors

Program Overview:

♦ An employee returns from lunch and smells like alcohol. What should you do?
♦ An employee has attendance or behavioral problems and you suspect substance abuse. What can be done?
♦ An employee tests positive following a random drug test. What happens next?

Dealing with behavioral issues in the workplace is always difficult. When you suspect that drugs or alcohol may be involved, things just get tougher.

Be part of this informative session and prepare yourself to handle the difficult supervisory task of addressing suspicion of drugs or alcohol in the workplace.

Topics to be Discussed Include:

♦ Managing the balance between employee rights and supervisory responsibilities
♦ A definition of “reasonable suspicion”
♦ Supervisor observation skills to identify potential substance abuse
♦ Documentation skills to minimize your liability and show your intent to protect the employee and the public
♦ State/Federal Law and industry “best practices”

Who Should Attend:
All staff who supervise and interact with employees who operate vehicles that fall under your organization’s Commercial Driver License (CDL) or Reasonable Suspicion Drug/Alcohol Program.

Program Length:
2 1/2 hours

Instructor: Workplace Solutions EAP staff.

Time of Year: This program is offered on a regional basis each Spring.

CEUs: CEUs are offered at a rate commensurate with the timeline of the program.

<table>
<thead>
<tr>
<th>Dates and Times</th>
<th>Locations</th>
<th>Fee</th>
<th>CEUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2007</td>
<td>Wheeling Park District</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00 am - 11:30 am</td>
<td>333 West Dundee Road</td>
<td>$10</td>
<td>.2</td>
</tr>
<tr>
<td></td>
<td>Wheeling, IL 60090</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wheeling Park District</td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 11, 2007</td>
<td>Fox Valley Park District</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00 am - 11:30 am</td>
<td>Vaughan Athletic Center Multipurpose Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2121 West Indian Trail</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aurora, IL 60506</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Registration Form

NAME of contact person submitting this registration form:____________________________________________

PLEASE PRINT CLEARLY BELOW:

Name:_______________________________________________E-mail:_____________________________

Agency:______________________________________________Position:____________________________

Department:__________________________________________Fax#:______________________________

Course and Location:______________________________________________________________________

Date of Course:_______________________________________ CEUs: Yes _____ No _____

Name:_______________________________________________E-mail_____________________________

Agency:______________________________________________Position:___________________________

Department:__________________________________________Fax#:______________________________

Course and Location______________________________________________________________________

Date of Course:_______________________________________ CEUs: Yes _____ No _____

Special accommodations are available—contact the Training Coordinator at 630-769-0332.

**IMPORTANT: Due to limited space available, NO onsite registration is allowed.**

Cancellation/No Show/Substitution Policy: With the focus of “hands-on” training to provide specific instruction and practical experience, small group-to-instructor ratios are necessary. Last minute cancellations or “no shows” prevent others from attending programs. Participants failing to cancel registration one week prior to the program must pay full registration fees.

Substitutes from the same agency are welcome.

**PAYMENT OPTIONS**

Payment: _____ Bill me _____ Check enclosed _____ Credit Card

Card type: Visa_______ Mastercard ______ Card Number _______________________________________

Amount to be billed to card $_______________ Card Expiration Date:___________________

Address associated with card:__________________________________________________________________________

I authorize the above expenditure to be charged to my credit card: (Please sign name) ______________________________

(Please print name) ______________________________

To register: Fax this form to PDRMA at: 630-435-8999 Mail to: PDRMA, P. O. Box 4320, Wheaton, Il 60189