CORPORATION
Alternative Safety & Testing Solutions

Substance Abuse Professional (SAP) Qualification Form

_____, an employer subject to the Department of Transportation drug and alcohol testing program, is required to verify the qualifications of all individuals who provide Substance Abuse Professional (SAP) services.

This form is designed to document the minimum qualifications. Please complete separate forms for each SAP that will be utilized for your company.

SAP Qualifications:

1. Name: _____
   (Please Print)
2. Business Address: _____
   _____
   _____
3. License or Certification:
   a. _____ M.D. or D.O
   b. _____ Licensed Social Worker
   c. _____ Certified Psychologist
   d. _____ Licensed or Certified employee assistance professional
   e. _____ Drug and alcohol counselor certified by:
      1. _____ NAADAC
      2. _____ ICRC
4. Source of Basic Knowledge: Indicate your knowledge and the source of your experience knowledge base.
   a. Knowledge and clinical experience in the diagnostic and treatment of alcohol and controlled substance related disorders.
      Source of knowledge and _____.
   b. Knowledge about SAP function as it relates to safety sensitive duties:
      Source of knowledge and _____.
   c. Knowledge about 49 CFR Part 40:
      Source of knowledge and _____.
   d. When did you first perform the role of Substance Abuse Professional as required by DOT? _____.

5. Modal Knowledge: I have knowledge of the following modal regulations concerning the drug and alcohol testing regulations:

a. _____ MCSA
b. _____ FAA
c. _____ FTA
d. _____ FRA
e. _____ RSPA
f. _____ USCG

6. Have you received qualification training as an SAP? If so,

   What Agency: _____

   Date of Training: _____

   Date of Examination: _____

   Please attach a copy of your certification

7. Comments: Please include any additional comments concerning your qualification to perform the SAP function.

8. Certificate of Accurate Information:

   I certify that the information provided above is accurate and correctly identifies my qualifications to provide DOT mandated drug and alcohol testing SAP services. I further certify that I will comply with all DOT required Continuing Education while providing these services for your company.

   Signature: _____ Date: _____

Thank you for your assistance in this critical component of our drug and alcohol testing program.

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