

FAIRFIELD CITY SCHOOL DISTRICT  
RETURN TO WORK CERTIFICATE

I, \_\_\_\_\_, a licensed  
physician (Medical Doctor or Doctor of Osteopathy), a licensed or certified psychologist, social  
worker, employee assistance professional or addition counselor certified by the National  
Association of Alcoholism and Drug Abuse Counselors Certification Commission, certify that \_\_\_\_

\_\_\_\_\_  
(Name of Employee)  
has full and unrestricted permission to return to his/her duties as a bus driver/chauffeur for the  
Fairfield City School District on \_\_\_\_\_  
(Date of return)

I also certify that \_\_\_\_\_  
(Name of Employee)  
has completed a program of assessment and rehabilitation, if required.

I also certify that as part of this certification to return to work \_\_\_\_\_  
(Name of Employee)  
must have unannounced follow-up testing for alcohol and/or controlled substances as follows  
(minimum of six tests in the first 12 months after return to work): \_\_\_\_\_

\_\_\_\_\_ agrees if he/she tests positive for alcohol and/or controlled  
(Name of Employee)  
substances in the future, his/her employment will be terminated immediately by the Fairfield  
City School District Board of Education.

\_\_\_\_\_  
Signature of Doctor, Counselor, etc.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

ACKNOWLEDGMENT OF POLICY AND MATERIALS

I have received a copy of the foregoing Commercial Drivers Alcohol and Drug Policy, including a copy of the Return to Work Certificate, have read its contents, have received information concerning the effects of alcohol and controlled substances use on an individual's health, work and personal life; signs and symptoms of an alcohol or a controlled substance problem; and available methods of intervening when an alcohol or a controlled substance problem is suspected, including confrontation; referral to an employee assistance program and/or referral to management and understand that I may be disciplined, up to and including termination of my employment, for failure to comply with the foregoing policy.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Employee's Name (Please Print)

\_\_\_\_\_  
Employer or Supervisor

\_\_\_\_\_  
Date