

Assessment/Treatment Report for DOT Positive Test

This form is to be completed by a substance abuse professional and filed with: **Department of Licensing**
 PO Box 9030
 Olympia, WA 98507
 Fax: **(360) 570-7044**

Please print or type

Driver's name (<i>Last, First, Middle</i>)		Washington driver license number
Residence address <input type="checkbox"/> PLEASE CHECK IF NEW ADDRESS		Date of birth
City	State	ZIP code
Mailing address <input type="checkbox"/> PLEASE CHECK IF NEW ADDRESS		
City	State	ZIP code
SAP name		SAP (Area code) Telephone number
SAP street address		
City	State	ZIP code
Check all appropriate boxes I am reporting: <input type="checkbox"/> a drug/alcohol assessment: _____ _____ _____ _____ _____ _____ _____ <input type="checkbox"/> a drug/alcohol treatment recommendation: _____ _____ _____ _____ _____ _____ <input type="checkbox"/> that this driver is satisfactorily participating in drug/alcohol treatment/education. <input type="checkbox"/> that this driver has successfully completed drug/alcohol treatment/education on: _____ Completion date		
Certification I certify under penalty of perjury under the laws of the state of Washington that I am a Department of Transportation qualified substance abuse professional meeting the requirements of 49 CFR Part 40.281 and that the foregoing is true and correct.		
Date and place	X Signature of Substance Abuse Professional	