

San Luis Obispo County Drug & Alcohol Services Application for Services



Client Name:		Date of Birth		Age	Gender:
Street Address:		City		State	Zip
Mailing Address (if different than above)		City		State	Zip
Home Phone		Cell Phone		Message Phone	
Work Phone					
Social Security No.			Driver's License No.		Driver's License State
Full name as it appears on your birth certificate:				Mother's <u>FIRST</u> name:	
BIRTHPLACE	IF CALIF. which COUNTY?		If NOT CALIF. which STATE?		If NOT USA which COUNTRY?
CHILDREN	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		Due Date	Number of children 6 to 17 years	*Number of children 0-5 years
	Children 0-5 Years give Name and Date of Birth				
PRIMARY LANGUAGE	English <input type="checkbox"/>	Spanish <input type="checkbox"/>	<input type="checkbox"/> Other (specify):		
MARITAL STATUS	Never married <input type="checkbox"/>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Separated <input type="checkbox"/>
ETHNICITY <i>choose up to 5</i>	White <input type="checkbox"/>	American Indian <input type="checkbox"/>	Korean <input type="checkbox"/>	Hawaiian <input type="checkbox"/>	Other Asian <input type="checkbox"/>
	Alaskan Native <input type="checkbox"/>	Hispanic <input type="checkbox"/>	Japanese <input type="checkbox"/>	Filipino <input type="checkbox"/>	Vietnamese <input type="checkbox"/>
	Laotian <input type="checkbox"/>	Asian Indian <input type="checkbox"/>	Black <input type="checkbox"/>	Chinese <input type="checkbox"/>	Samoan <input type="checkbox"/>
	Guamanian <input type="checkbox"/>	Cambodian <input type="checkbox"/>	Mixed Race <input type="checkbox"/>	Other Race <input type="checkbox"/>	
SCHOOL	High School <input type="checkbox"/> College <input type="checkbox"/> Highest Year Completed:				
MILITARY	Active military <input type="checkbox"/> Discharged <input type="checkbox"/> Veteran <input type="checkbox"/> Have Veteran Benefits <input type="checkbox"/>				
WORK	Employed full-time <input type="checkbox"/> (35 hours or more) Part time <input type="checkbox"/> (Less than 35 hrs) Unemployed <input type="checkbox"/> (Looking for work) Unemployed <input type="checkbox"/> (Not looking for work) Not in the labor force <input type="checkbox"/> (Not seeking work)				
INCOME	Are you on Medi-Cal? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you a CalWORKs Participant? Yes <input type="checkbox"/> No <input type="checkbox"/>		Approximate your monthly income \$
	Number of people living on income including you:				
DISABILITY <i>Can choose more than 1</i>	None <input type="checkbox"/> Visual <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Mobility <input type="checkbox"/> Mental <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Other (not drug or alcohol) <input type="checkbox"/>				
EMERGENCY INFORMATION	Person to notify in case of an emergency:				Relationship to you:
	Home Phone		Cell Phone	Work Phone	Address:
REFERRAL INFO	Referred by (Court/Agency/Person)		Have you been seen by us before? Yes <input type="checkbox"/> No <input type="checkbox"/> How long ago? _____		
LEGAL	Probation Officer Name		Court Case #	CDC #	Parole Officer Name

SERVICE AUTHORIZATION: I, the undersigned, am agreeing to drug and alcohol services and give my consent to the staff of the San Luis Obispo County Drug and Alcohol Services to administer such screening, assessment, and services as considered therapeutically necessary and/or desirable. All procedures, including observed urinalysis for drug of abuse, patching, and Breathalyzer, are to be discussed with me and I am free to decline or withdraw from services at any time. I expect to receive quality, professional care and understand that there is no guarantee that desired results will be obtained. I will be given a copy of the service plan, which may include referral to other services including: residential placement, detoxification services, employment and educational services, and other services as deemed necessary.

I understand that San Luis Obispo County Drug and Alcohol Services will maintain a record of my service contacts as required by law. Law protects the confidentiality of these records and no information that might identify me will be released without my specific written consent. Exceptions to this confidentiality are: medical emergencies, a Judge's order to release information to a court, unreported abuses of a child, dependent adult or elder, or in the event that I am of danger to myself or others.

Client Signature _____ **Date** _____

Witness, when needed _____ **Date** _____

CLIENT NAME: _____ **CLIENT #** _____

SLO DRUG AND ALCOHOL SERVICES HEALTH QUESTIONNAIRE

General Health Information

1. Date you last saw a doctor? _____	2. What was the purpose of the visit? _____	3. Date of your last physical? _____
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*4. Med-2 How many times have you visited an Emergency Room in the past 30 days? _____

*5. Med-3 How many days in past 30 have you stayed overnight in a hospital for physical health problems? _____

*6. Med-4 How many days in the past 30 have you experienced physical health problems? _____

*7. Med-7 Were medications prescribed by Drug and Alcohol Services as a part of your treatment? Yes No

8. Ever had surgery? Yes No If yes, for what: _____

*9. Med-8 Have you ever had a positive TB Test? Yes No
Date of last TB Test _____

*10. Med-9 Have you been diagnosed with Hepatitis C? Yes No Did you receive your test results? Yes No
Date of last test: _____

*11. Med-10 Have you been diagnosed with a Sexually Transmitted Disease? Yes No
Did you get treated? Yes No Date of last test: _____

*12. Med-11 Have you been TESTED for HIV? Yes No
*Med-12 Did you receive results of the test? Yes No Date of last HIV Test: _____

*13. <small>Med-5</small> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your due date? _____	Date of last menstrual period? _____	Date of last GYN exam? _____
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14. Allergic to anything? Yes No If Yes, what? _____

15. Do you have frequent blackouts? Yes No How frequently? _____

16. Have you EVER injected drugs? Shared needles? Shared cottons? Yes No *IF YES check all that apply*

*ADU-10 How many days in the past 30 have you injected drugs? _____ Last time injecting: _____

17. List any prescription medications, including psychiatric medications; you are currently taking and the name of the doctor who prescribed them.

Mental Health Questions

18. *MHD-1 Have you ever been diagnosed with a mental illness Yes No Were you treated? Yes No
What type Treatment? Outpatient? Inpatient?

What was the diagnosis? _____

*MHD-2 How many times in the past 30 days have you received outpatient emergency services for mental health needs? _____

*MHD-3 How many days in the past 30 days have you stayed 24 hours or more in a hospital or psychiatric facility for mental health needs? _____

*MHD-4 In the past 30 days, have you taken prescribed medication for mental health needs? Yes No
If yes, list the psychiatric meds prescribed for you, dosage, and the physician who prescribed them.

19. Past suicide attempts? Yes No How many attempts? _____ Date of most recent attempt _____
How did you try to commit suicide? _____

Section 1: HAVE YOU EVER HAD

20. List any over-the-counter medications you take and how often (Ibuprophen, Alleve, Tylenol, Aspirin, Tums, Pepto Bismol, Imodium, etc.)

22. Any serious health problems (such as tuberculosis or active pneumonia) that may be contagious to others around you? Yes No
Give Details: _____

23. History of any other illness that may require frequent medical attention? Yes No Give Details: _____

24. A stroke? Yes No If yes give details: _____

25. Head injury that resulted in loss of consciousness? Yes No Date of injury: _____
If yes give Details: _____

CLIENT NAME: _____	CLIENT NUMBER: _____
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26. Seizures, epilepsy, delirium tremens or convulsions? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last seizure:If yes give details:	
27. Do you get a lot of diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No	28. Do you cough up blood? <input type="checkbox"/> Yes <input type="checkbox"/> No
28. Do you have an abscess? <input type="checkbox"/> Yes <input type="checkbox"/> No	29. Do you have sores that will not heal? <input type="checkbox"/> Yes <input type="checkbox"/> No
30. Weight loss without trying? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. Fever (over 100) and chills? <input type="checkbox"/> Yes <input type="checkbox"/> No
32. Swollen lymph nodes? <input type="checkbox"/> Yes <input type="checkbox"/> No	33. Night sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Chest pains? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES please give details:	
Section 2: HAVE YOU EVER HAD	
34. Been diagnosed with diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No What type of medication and/or diet do you use to control the diabetes? Give details:	
35 Heart attack or any problem associated with the heart? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: of Heart Attack: Give details:	
36. Blood clots in your legs or elsewhere that required medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No When?	
37. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	38. Are you anemic? <input type="checkbox"/> Yes <input type="checkbox"/> No 39. Bleeding problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
40. History of cancer for you or your family? <input type="checkbox"/> Yes <input type="checkbox"/> No Give Details:	
41. Problems with thyroid glands or hormones? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
42. Arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Back pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
44. Do you get dizzy or faint? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how often?	
45. Have you ever overdosed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes on What? When?	
Section 3: HAVE YOU EVER HAD	
46. Excessive heartburn or abdominal pains? <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No
48. Bladder/Kidney infections? <input type="checkbox"/> Yes <input type="checkbox"/> No	49. Unusual genital discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No
50. Pain with urination? <input type="checkbox"/> Yes <input type="checkbox"/> No	51. Kidney problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
52. Menstrual problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	
53. <input type="checkbox"/> Hepatitis or <input type="checkbox"/> other liver illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES check which one Give Details:	
54. Lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No If YES check which one <input type="checkbox"/> Asthma? <input type="checkbox"/> Emphysema? <input type="checkbox"/> Chronic bronchitis? Give Details:	
55. Do you wear: <input type="checkbox"/> Eye Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> none Check which one)	
56. Are you in need of dental care? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: Date of last dental exam:	
58. Do you wear dentures or other dental appliances that require care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes explain	
59. Have you had any body piercing? <input type="checkbox"/> Yes <input type="checkbox"/> No	60. Have you had any tattoos? <input type="checkbox"/> Yes <input type="checkbox"/> No
TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS ACCURATE AND TRUE:	
Client Signature:	Date:
Therapist note: The physician or nurse must make a recommendation and sign this form first before client and counselor sign	
AS THE DRUG AND ALCOHOL SERVICES MEDICAL STAFF, I HAVE REVIEWED THIS FORM AND RECOMMEND THE CLIENT:	
<input type="checkbox"/> Begin treatment that you are referred to	<input type="checkbox"/> HIV and or Hep C Test if at risk or for 6 month window
<input type="checkbox"/> Physical examination NOW	<input type="checkbox"/> TB Test every year
<input type="checkbox"/> Yearly physical exam including lab tests	<input type="checkbox"/> Pregnancy Test
<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> Needs Medical Evaluation before entrance to program
<input type="checkbox"/> Counseled about signs/symptoms of withdrawal. Referred for Detox_____	
1st Medical Staff Signature:	Date:
I have informed the client that the Drug and Alcohol Services medical staff made the above referrals for them.	
2nd Therapist Signature:	Date:
By signing this form I am signifying that I have been informed that the San Luis Obispo Drug and Alcohol Medical Staff made the above marked recommendations for me.	
3rd Client Signature:	Date:

Notice of Privacy Practices

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Under these laws, County of San Luis Obispo Drug and Alcohol Services ("SLO DAS") may not say to a person outside SLO DAS that you attend the program, nor may SLO DAS disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal and state law.

SLO DAS must first obtain your written consent before it can disclose information about you for payment purposes. For example, SLO DAS must obtain your written consent before it can disclose information to MediCal in order to be paid for services. Generally, you must also sign a written consent before SLO DAS can share information for treatment purposes or for health care operations. However, federal and state law permits SLO DAS to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/business associate;
2. For research, audit or evaluations;
3. To report a crime committed on SLO DAS's premises or against SLO DAS personnel;
4. To medical personnel in a medical emergency;
5. To appropriate authorities to report suspected child abuse or neglect;
6. As allowed by a court order;
7. To appropriate authorities to report suspected dependant adult abuse or neglect.

For example, SLO DAS can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before SLO DAS can use or disclose any information about your health in a manner, which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. You may revoke any such written consent in writing.

Your Rights

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. SLO DAS is not required to agree to any restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. SLO DAS will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by SLO DAS, except to the extent that the information

contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information contained in SLO DAS's records, and to request and receive an accounting of disclosures of your health related information made by SLO DAS during the six years prior to your request. You also have the right to receive a paper copy of this notice.

SLO DAS Duties

SLO DAS is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. SLO DAS is required by law to abide by the terms of this notice. SLO DAS reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. We will keep a copy of the current notice posted in our reception area, and will offer you a copy of the amended privacy notice at your appointment.

Complaints and Reporting Violations

You may complain to SLO DAS and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. Complaints should be directed to our Privacy Officer:

Colin Quennell – Privacy Officer
Drug and Alcohol Services
County of San Luis Obispo
2945 McMillan St. Suite 136
San Luis Obispo, CA 93401
805-473-7085

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Contact

For further information, contact Colin Quennell, Privacy Officer, (805) 473-7085.

Effective Date

Effective date of this notice of privacy practices is April 14, 2003.

Drug and Alcohol Services
San Luis Obispo County

**Acknowledgement of Receipt of
Notice of Privacy Practices**

Name of Patient: _____

I hereby acknowledge that I received a copy of County of San Luis Obispo Drug and Alcohol Service's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____

Date: _____

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

CLIENT NAME: _____

CLIENT NUMBER: _____

**SAN LUIS OBISPO COUNTY DRUG AND ALCOHOL SERVICES
HIV, HEPATITIS C AND TB INFORMATION**

What is AIDS?

Acquired Immune Deficiency Syndrome is caused by a virus called HIV (Human Immunodeficiency Virus). The virus can destroy the body's ability to fight off infection. The person may then get sick and not be able to get well again.

How do you get HIV?

Participating in high risk behaviors such as: unprotected sex—vaginal/anal/oral, needle sharing—tattoo needles included; having sex with someone who does the above; exchanging sex for money or drugs. Having a sexually transmitted disease may put you at increased risk for contracting HIV. The virus can pass from mother to baby. Before HIV testing transfusions weren't safe, now they are.

How can you find out if you have HIV?

There is a special test called the HIV antibody test. If the test result is "Positive," it shows that you are infected with HIV. It does not tell you if you have AIDS. You need to see a doctor to find that out. If the test is "Negative," it means you either have not been infected or not enough time has passed to show the infection (6 months). *Please answer the two questions at the bottom of this form to obtain more information or to arrange for testing.*

What is Hepatitis C?

Hepatitis C is a liver disease cause by the hepatitis C virus, which is found in the blood of persons who have this disease. Hepatitis C is serious for some persons, but not for others. Most people who get Hepatitis C carry the virus for the rest of their lives.

How Do You Get Hepatitis C?

Hepatitis C is spread by contact with an infected person's blood. Examples of this include: sharing drug injection equipment (including things other than the syringe); having received a blood transfusion prior to 1992; having multiple sexual partners; and possibly sharing razors, toothbrushes, tattoo and piercing equipment.

How Do Know if You Have Hepatitis C?

Many persons with long-term hepatitis C have no symptoms and feel well. For some persons, the most common symptom is extreme tiredness. The only way to know if you've been infected is to have a blood test that looks specifically for the hepatitis C virus.

What is TB?

"TB" is short for a disease called *Tuberculosis*. The TB germ is spread from person to person through the air. If someone coughs, sneezes, laughs, or shouts the germs are put into the air and people nearby can breathe TB germs into their lungs.

Who gets TB?

Anyone can get TB, but substance users and people who have AIDS are at higher risk. Living in an environment with a lot of other people or being homeless also increases the chances of being exposed to TB.

How do you know if you have TB?

A skin test is the only way to tell if you have been exposed to TB. A chest X-ray can tell if there is damage to your lungs from TB disease. Having the disease can cause symptoms such as weakness, weight and/or appetite loss, high fever, or sweating a lot at night. If you have ever had any of these symptoms please tell your doctor.

Please read and circle the answers below:

I am interested in receiving more information about:

HIV Hep C TB None

I am interested in arranging testing for:

HIV Hep C TB None

I have read and understand the above information. Yes No

Client Signature

Date

Client Name _____ **Client #** _____

SAN LUIS OBISPO COUNTY Drug & Alcohol Services PROGRAM
Client Drug Testing Guidelines & Drug Free Zone Policy

Poppy seeds: Eating poppy seeds—as little as one muffin’s worth—will result in a positive morphine (opiate) urine test. Therefore, do not eat food containing poppy seeds while you are a client at San Luis Obispo County Drug & Alcohol Services. Since you have been warned, all drugs screen that result in a positive for opiates will be considered to be caused by illegal drug use and appropriate action will be taken. If you claim a positive test is due to poppy seeds, your urine sample will be sent, at your expense, to an out-of-county laboratory capable of differentiating between opiates and poppy seeds. Test results can take in excess of three weeks to return.

Energy packets, herbal formulas, Metabolife, or energy drinks: Many of these formulas contain ephedrine or other type of stimulants that may show positive for amphetamines on a drug screen. Please avoid all use of these items while in treatment.

Prescription Medications: Non-narcotic over-the-counter and non-narcotic prescription medications for pain are available. Therefore, if you are in need of a pain reliever, ask your pharmacist to recommend—or your physician to prescribe—medications that are non-narcotic and will not result in a positive drug screen.

Other medications such as allergy and cold medicines may contain ingredients that will result in a positive amphetamine test. Ask for information from your pharmacist or physician before ingesting any over-the-counter or prescription medicines you do not know for certain to be free of substances that will result in a positive drug screen.

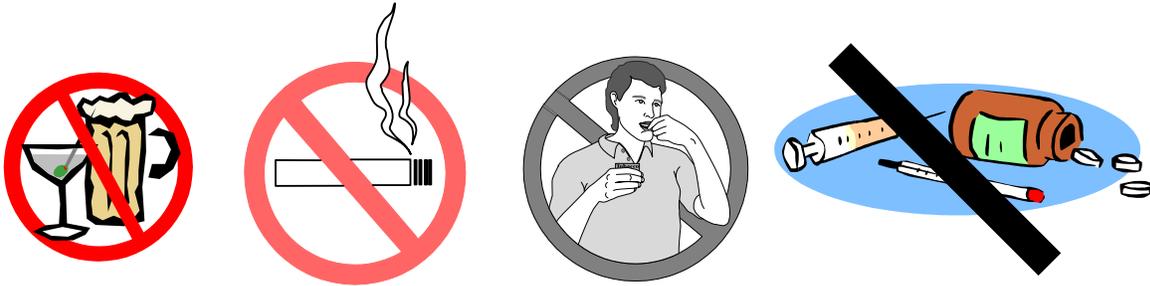
If for some reason your physician believes you must take a narcotic or other medication that will result in a positive drug screen, you must obtain a note from your physician stating no other medication would meet your need. Treatment staff will review all prescription drug use.

Drug Free Zone Policy

Client Statement of Understanding and Compliance

I understand that San Luis Obispo County Drug and Alcohol Services is a *Drug Free Zone* and that:

1. Alcohol or other drug use is not permitted. This includes all tobacco products (cigarettes, cigars or chewing tobacco).
2. Smoking or chewing tobacco is not permitted in the immediate area of the building, but is permitted, *by adults*, in private vehicles and on public sidewalks.
3. Proper use of legal medications is permitted.



I have read and understood the above:

Client Signature and Date _____

Specialist Signature and Date _____

Client Name: _____ **Client #:** _____



Participant's Certification of DUI Program Enrollment or Completion

(Instructions for completing this form are on the reverse side.)

PROGRAM PROVIDER NAME SAN LUIS OBISPO COUNTY DRUG & ALCOHOL SERVICES			PROVIDER'S ADP LICENSE NUMBER 40-001-01-120	
PARTICIPANT NAME: (LAST FIRST MIDDLE)			DRIVER LICENSE NUMBER OR "X" NUMBER	
PROGRAM TYPE				
<input type="checkbox"/> Education Only (23140 CVC Conviction) <input type="checkbox"/> First Offender Program ___ months <input type="checkbox"/> Multiple Offender Program ___ 18 months ___ 30 months ___ 18 of 30 months (IID Restriction only)				
ENROLLMENT DATE	DL 107 CERTIFICATE NUMBER	OR	COMPLETION DATE	DL 101 CERTIFICATE NUMBER
<i>I certify under penalty of perjury under the laws of the State of California that I have enrolled in, or completed the program as indicated above.</i>				
DATE	PARTICIPANT'S SIGNATURE 			TELEPHONE NUMBER ()

DL 804 (REV. 1/2003) WWW

Instructions for Completing the Participant's Certification of DUI Program Enrollment or Completion (DL-804)

This form is to be used under the following circumstances:

- When a program participant has completed all the required DUI Program components, but you are unable to immediately issue a Notice of Completion Certificate (DL 101) and capture the participant's signature on the (paper) completion certificate.
- When a program participant has completed all the required DUI program components and you are submitting an electronic Notice of Completion Certificate (DL 101) via an authorized Internet access link with the Department of Motor Vehicles (DMV).
- When a program participant has enrolled in a DUI program and you are submitting an electronic Proof of Enrollment Certificate (DL 107) via an authorized Internet access link with the DMV.

This form captures the participant's signature, which certifies under penalty of perjury that the participant has either enrolled in a DUI program, or completed the required DUI program. This signature would normally be on the DL 101 or DL 107, but in the above circumstances you may not be able to capture the participant's signature on the certificate.

Please, ensure that the information on this form is consistent with the information on the Proof of Enrollment Certificate (DL 107) or the Notice of Completion Certificate (DL 101) you submit for the identified participant.

You must retain this form in your office in a manner that will allow you to retrieve it by searching for the serial number of the corresponding Certificate (DL 107 or DL 101) and for the period required by Section 9866 of Title 9, California Code of Regulations.

On the printed Notice of Completion Certificate (DL 101) you submit without a participant's signature, type or print the words "Signed DL 804 in file" in the space provided for participant's signature.

Do not submit a DL 804 to DMV unless you are requested to do so.

DL 804 (REV. 1/2003) WWW