Ohio | Bureau of Workers' Compensation

Drug-Free Safety Program (DFSP) Annual Report – Basic and Advanced Levels

Please complete this form and return it with requested information, including required attachments as directed by BWC.

Employer information

Name of employer and DBA	Federal Tax ID number	BWC policy number
Sigma Manufacturing	37-1111111	09999999

Address	City	State	ZIP code
111 Anywhere Dr., E.	Washington	OH	45111

Telephone number	Fax number
111-000-9999	000-999-1111

Email address: manufacturing@sigma.com

Contact information

Contact name: William Smith

Contact title	Contact email
HR Manager	Company@hotmail.com

Contact telephone number	Contact fax number
614-555-7285	614-555-2447

Program information

Current program level: Basic

This form is the annual report of progress due by the last business day of September for the January program year and by the last business day of March for the July program year. The intent of this report is for the employer to provide sufficient documentation of compliance with all program requirements. Please fill in the requested information below with the understanding you must submit all required attachments and answer all required questions to document compliance and receive/retain a DFSP discount. If you check the No box in response to any of the Yes/No questions, you must provide an explanation since each of these questions involves a requirement to remain in the DFSP at the approved program level. Attach explanations and any other pertinent information on additional sheets as appropriate.

Select the program/level you wish to participate in for the next program year *(check one only).*

- ☑ Advanced
- ☐ Basic
- ☐ Comparable (state construction only)
- ☐ I do not wish to participate next program year. I understand that future participation will require timely submission of a new application (U-140).

The employer in this example is in the Basic level and selects "Advanced" level for the next program year. Note below where "Advanced" is circled to indicate where information would need to be provided on the next Annual Report.

Answer each statement on this report by checking the appropriate Yes/No box and/or by providing requested information. All No answers require an explanation.

1. General information

Total number of employees reported under this policy: 94

Number of new hires during this program year: 12

2. Safety requirements

a. Our company has completed the required online safety review during this program year. Yes ☑ No ☐

b. Our company has completed the required accident-analysis training for all supervisors and other appropriate personnel. Yes ☑ No ☐

c. If yes, was training completed ☐ Online - BWC Learning Center ☑ Other

d. If you answered Other: Our company will submit documentation (e.g., sign-in sheet) for accident-analysis training. Yes ☑ No ☐

e. Our company submitted an accident report for each allowed workers' compensation claim that occurred during the program year. Yes ☑ No ☐

f. **(Advanced level only)** Provide an update on your safety action plan. Describe the accomplishments and/or progress you have made or are making with the specific activities identified in your action plan.

Program information

3. Written DFSP policy

a. Our company has developed (or maintained) a written policy that complies with the requirements of the DFSP level that we are participating in for this program year. Yes ☑ No ☐

b. I have previously submitted a copy of my written DFSP policy. Yes ☑ No ☐

4. Employee education

a. Our company has initiated and is maintaining employee education that complies with the requirements of our DFSP level for this program year, using services from a qualified substance professional. Yes ☑ No ☐

b. Indicate below the name(s) of the qualified substance professional(s) who provided drug-free substance education sessions to your employees and supervisors for this program year, their credentials, the name of their company(ies) and the dates (month/day/year) on which these sessions occurred.

Name(s)/credentials of vendors who provided employee education sessions this program year: Month/Day/Year held

Cincinnati Recovery Services, Sam Pathy 9/24/2014

LICDC

5. Supervisor training

a. Our company has initiated and is maintaining supervisor training that complies with our DFSP level requirements, including covering all required substance abuse topics and offered through a qualified substance professional. Yes ☑ No ☐

b. Indicate below the name(s) of the qualified substance professional(s) who provided supervisor skill-building training to your supervisors for this program year, their credentials, the names of their company(ies) and the dates (month/day/year) on which these sessions occurred.

Name(s)/credentials of vendors who provided supervisor training sessions this program year: Month/Day/Year held

Cincinnati Recovery Services, Sam Pathy 9/24/2014

LICDC

6. Alcohol and other drug testing

a. Our company has initiated and is maintaining the full range of substance testing in compliance with the requirements of our program level. Yes ☑ No ☐

b. Below, record the total number of alcohol or drug tests by type of test (pre-employment, etc.).
Then, for each substance (alcohol and each listed drug), record number of positives under each type of test.

c. If your company had any positive test results, please indicate below by gender and age range the number of tests for each category.

Number of positive tests by age ranges and gender

	Male	Female	Total
i. Under 21	1	1	2
ii. 22-30	2		2
iii. 31-40		1	1
iv. 41 and over			

	Number of positive tests by type of substance found													
	Total number of tests	Alcohol	Amphetamines	Cocaine	Ecstasy	Marijuana	Opiates	PCP/Angel Dust	Barbiturates	Benzodiazepines	Methadone	Oxycodone	Propoxyphene	Other
Pre-employment/new hire	12			1		1								
Reasonable suspicion	4						2							
Post accident	3	1												
Return to duty	1													
Follow-up	1													
Random	0													

Program information

d. Our company has contracted to use services of a collection site, which follows the specimen collection and testing protocols that meet federal testing requirements, including analysis of urine specimens by a laboratory certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). We will submit a copy of a collection/testing invoice each year. Yes ☑ No ☐

e. Complete the information below. (Please do not leave any of these blank.)

i. Name of collection site or consortium: Epic, LLC

ii. Name of contact person at collection site or consortium: Pete Puchien

iii. Phone number of collection site or consortium: 513-111-0000

iv. Name of certified medical review officer used: Kim Johnson, M.D.

v. SAMHSA-certified laboratory used for urine analysis: Dyna Lab, Inc.

f. **(Advanced level only)** Our company is complying with the 15-percent random drug testing requirement through employees being in a company-only random drug testing pool. Yes ☐ No ☐

g. **(Advanced level only)** Our company is complying with the 15-percent random drug testing requirement through a consortium. Yes ☐ No ☐

If you answered "Yes," The name of the consortium is _____, the contact person is _____ and the contact person's phone number is _____.

7. Employee assistance

a. Our company has a list of local assistance resources to refer an employee who tests positive for alcohol or other drugs or who comes forward voluntarily to request help. Yes ☑ No ☐

b. List one company or individual that offers employee assistance services from the list your company has compiled.

i. Hamilton County Recovery Services.

c. Fill in the information below to describe the results of positive tests at your company this program year.

i. Number of employees who tested positive and were terminated for positive test: 3

ii. Of those who tested positive and were given a second chance:

1. Number who failed a substance test after being given a second chance: 0
2. Number who passed a substance test after being given second chance: 1

iii. **(Advanced level only)** Of those who tested positive but were not given a second chance:

1. Number terminated due to specimen adulteration/substitution: _____
2. Number terminated due to refusal to test: _____
3. Number terminated based on position/job function being safety sensitive: _____
4. Number terminated due to a reason not specified in 1, 2 or 3: _____

a. Describe reason for termination: _____

(Advanced level only)

d. Our company has established and pays for substance assessments offered through an employee assistance professional. Yes ☐ No ☐

e. List the name of the company or individual that offers substance assessment services to whom you refer employees who test positive or request help with a substance abuse problem.

i. _____.

Program information

Certification Statement

Your signature below, as the designated representative for this employer, signifies you have submitted a complete and accurate report. If your company fails to submit a fully completed Annual Report and required attachments by the required deadline or has failed to meet all program requirements, BWC will remove your company from its DFSP.

In addition, if you are a state construction contractor, BWC will remove you from the state construction database, and you will no longer be eligible to bid or work on state construction projects. BWC may conduct an audit of any participating employer's program. Your signature constitutes acknowledgment of the possibility of BWC auditing you and your willingness to cooperate with such an audit as a condition of program participation.

I hereby certify my organization has implemented all components of DFSP in accordance with, at minimum, the requirements specified for our approved program level. I understand that my signature constitutes my company's certification of compliance with BWC's program requirements and – if this Annual Report and/or any attachments are not accurate – may be considered a fraudulent representation on the part of the employer and may subject me to civil and criminal penalties. It may also result in the taking back of bonus and removal from current and/or future program participation.

Printed name of designated employer representative	Title
Charles Franklin	3/24/2014
Signature of designated employer representative	Date of submission

Check list of required documents for submission to BWC in addition to this report

- ☐ Documentation (for example, sign-in sheet) for accident analysis training UNLESS training was completed online through BWC Learning Center
- ☐ Copy of written DFSP policy if not previously submitted
- ☐ Invoice for employee education
- ☐ Sign-in sheet for employee education
- ☐ Invoice for supervisor training
- ☐ Sign-in sheet for supervisor training
- ☐ Invoice for collection/testing
- ☐ **(Advanced level only)** invoice from a consortium (if one was used) and letter on consortium letterhead that states employer is member of a consortium and that employees are in a pool that draws at 15 percent or higher IF consortium is used to meet random drug-testing requirement
- ☐ Explanation for any "No" responses in completing the Annual Report