



Please complete this form and return it and requested information, including required attachments to BWC at the fax number you have received.

Employer name: _____ Policy number: _____

Address: _____

Current program level: _____ Federal ID: _____

Do you have access to internet services? Yes No

Send correspondence to me at the following e-mail address: _____

This form is the annual self-assessment 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. 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 need to provide an explanation since each of these questions involves a requirement to remain in the DFSP at the approved program level.

Program information

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

- Advanced
 Basic
 Comparable (state construction only)
 I do not wish to participate next program year.

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

Number of employees (average number for the program year): _____

Number of new hires during this program year: _____

2. Safety requirements

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

b. If you answered yes to question 2a, on what date(s) did you complete the online safety review? _____
Month(s)/day(s)/year

Describe below what your company learned from the review in terms of workplace safety and what safety improvements you have made or are working on.

Three horizontal lines for describing safety improvements.

Advanced level only

c. Provide an update on your safety action plan. Describe the accomplishments and/or progress you have made or are making with the specific activities you defined in your action plan.

Two horizontal lines for providing an update on the safety action plan.

If you fail to provide a safety action plan update in 2c above, BWC will move you from the Advanced DFSP to the Basic DFSP with the appropriate reduction in benefits for this program year.

Program information

3. Written substance 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

Required attachment: Copy of written substance policy (to be submitted one time only)

- b. I have submitted a copy of this policy previously or have attached one to this report. 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

Required attachment: Copy of an invoice from a qualified substance professional for employee education services

- c. Our company has provided the required employee education invoice and one sign-in sheet. Yes No

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 being offered through a qualified substance professional. Yes No
- b. Our company has completed accident-analysis training in accordance with program requirements. Yes No
- c. 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 employee education sessions this program year: Month/Day/Year held

Required attachments: Copy of an invoice from a qualified substance professional for supervisor training and one sign-in sheet

- d. Our company has provided the required supervisor training invoice and one sign-in sheet. Yes No

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.

		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														
Reasonable suspicion														
Post accident														
Return to duty														
Follow-up														
Random														

Program information

- 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	_____	_____	_____
ii. 22-30	_____	_____	_____
iii. 31-40	_____	_____	_____
iv. 41 and over	_____	_____	_____

- 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). Yes No

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

- i. Name of collection site or consortium: _____
- ii. Name of contact person at collection site or consortium: _____
- iii. Phone number of collection site or consortium: _____
- iv. Name of certified medical review officer used: _____
- v. SAMHSA-certified laboratory used for urine analysis: _____

Required attachment: Copy of an invoice from a collection site for DFSP testing services

- f. Our company has provided the required collection/testing invoice. Yes No
- g. **(Advanced level only)** Our company is compliant with the requirement of 15-percent random drug testing, either through employees being in a company-only random drug testing pool or through a consortium that "draws" at least 15-percent. Yes No
- h. **(Advanced level only)** If your company complies with the 15-percent random drug testing requirement through the services of a consortium, you must list the name of the consortium, a contact person and phone number and submit an invoice from the consortium and a letter on consortium letterhead that states that you are a member of the consortium for this program year and that your employees are in a pool that draws at 15-percent or higher.

Our company is complying with the 15-percent random drug testing requirement through a consortium. The name of the consortium is _____, the contact person is _____ and the contact person's phone number is _____.

- i. **(Advanced level only)** Our company has a letter on consortium letterhead that states that we are a member of the consortium for this program year and that our employees are in a pool that draws at 15-percent or higher, and we are submitting these documents. If you are not submitting the documentation from the consortium, you must submit an explanation below. Yes No

7. Employee assistance

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

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

i. _____

- 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: _____

ii. Number of employees who tested positive and were given a second chance: _____

1. Number who failed a substance test after being given a second chance: _____

2. Number given second chance and help and didn't test positive again: _____

iii. **(Advanced level only)** Number of employees testing positive but not given second chance due to being terminated based on a first positive test.

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: _____

Program information

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. _____.

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 Self-Assessment Progress 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 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 Self-Assessment Progress Report and/or any attachments are not accurate – may be considered a fraudulent representation on the part of the employer and me subjects to civil and criminal penalties. It may also result in the taking back of discounts and removal from current and/or future program participation.

Signature of designated employer representative

Date of submission