

**FOUND IN THIS SECTION ARE:**

**Drug Free Workplace & Policy**

**(Spanish translations are directly behind English versions)**

- 1. 60-Day Notice or Notice to all Employees**
- 2. Employment Acknowledgement Forms**
- 3. Medication Disclosure Form**
- 4. Drug Free Workplace Employee Handbook**

# AN OPEN LETTER TO ALL EMPLOYEES OF

## Tropic Fire Protection, Inc.

Drug and alcohol abuse affects everyone, regardless of age, profession, ethnic, and educational background. The use of illegal drugs, abuse of alcohol and prescription medications has entered the workplace at an alarming rate. Some consequences include:

- Increased absenteeism, tardiness, and work-related injuries;
- Decreased productivity and poor job performance;
- Theft
- Relationship problems between co-workers and our clients.

The time has come for all of us to recognize that substance abuse is a problem in this state and country. You may not personally abuse drugs, but tolerance of such abuse enables it to flourish. We believe use of illegal drugs and abuse of prescription drugs and alcohol endangers the health and safety of the abusers, their family, friends and co-workers.

Tropic Fire Protection, Inc. has adopted a Standard of Conduct that formally states that **substance abuse will not be tolerated**. The prohibition includes, but is not limited to, the possession, manufacture, use, transport, sale, or attempt to sell illegal drugs and the irresponsible use of alcohol. We are committed to creating a **DRUG FREE WORKPLACE**, without jeopardizing our valued employees' job security.

### **CURRENT EMPLOYEES**

After an initial **sixty-day period**, which begins, \_\_\_\_\_, **2004** all current employees will be subject to drug and/or alcohol testing, in certain situations, as outlined in the company policy. Employees who refuse testing will be terminated. Additional information about the program will be made available in the near future.

### **NEW HIRES**

Effective immediately, all new hires will be subject to mandatory pre-employment drug testing.

Our company has the right to ensure a safe working environment and to employ a staff that is free from the effects of substance abuse.

## OVER THE COUNTER AND PRESCRIPTION MEDICATION DISCLOSURE

I, the undersigned employee, hereby acknowledge that I have read a copy of over-the-counter and prescription medications, which may affect the results of a drug or alcohol, test. The following is a list of all such medications that I have used in the past thirty (30) days, which I am providing voluntarily to the Human Resource Director and Medical Review Officer. I understand that the company shall treat this information as confidential.

Name of Medication:

\_\_\_\_\_ Prescription

\_\_\_\_\_ Prescription

\_\_\_\_\_ Prescription

\_\_\_\_\_ Prescription

Name of Medication:

\_\_\_\_\_ Non-Prescription

\_\_\_\_\_ Non-Prescription

\_\_\_\_\_ Non-Prescription

\_\_\_\_\_ Non-Prescription

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

\_\_\_\_\_  
Print Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**NOTE: Completion of this form is voluntary and will not affect the drug test process. All laboratory results are reported to the company designated Medical Review Officer (MRO). If your results are reported as a positive to the MRO, he/she must try to contact you to review the results of the drug test to see if there is a medical reason (medication) for your positive result. If the reason for your positive result was due to medication, you must provide the MRO with proof of your prescription. The MRO will then change the result from a positive to a negative drug test result, without disclosing your medication. If your result is negative, it will be reported directly to this company.**



## EMPLOYMENT ACKNOWLEDGMENT AGREEMENT

I hereby acknowledge that I have received this company's Drug Free Workplace Handbook, which includes the company Drug Free Workplace policy, employee assistance information, a listing of drugs being tested for, common over-the-counter medications which may alter a drug test and educational material on substance abuse. I have also been given the opportunity to voluntarily complete a Medication Disclosure Form.

I freely and voluntarily agree and realize that as part of my employment, I may be subjected to future drug and/or alcohol screens for post-accident, reasonable suspicion, routine fitness-for-duty, return to work, follow-up, and/or random testing at the company's discretion. I understand that a refusal to submit to a blood, urinalysis, hair and/or breath test will result in immediate termination from employment. I understand that a tampered or an adulterated drug and/or alcohol specimen will be considered a refusal to test, resulting in immediate termination. I understand that a confirmed positive drug and/or alcohol test will result in immediate termination of employment, but if I am able to successfully complete substance abuse treatment at my expense, and if a job is still available, I may be given one chance to be rehired, upon a negative return to work drug and/or alcohol test. I understand that I will be subject to the company rehabilitation agreement and I will undergo random follow-up drug and/or alcohol tests for a period of 2 years. I understand that a confirmed positive drug and/or alcohol follow-up test or any violation of the rehabilitation agreement will result in termination of employment.

I agree to voluntarily submit to a blood, urinalysis and/or breath test for drug or alcohol use as part of my ongoing employment, and I release my employer from any liability resulting from my participation in such a screening. I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits under Florida's workers' compensation law (Florida Statutes 440.101, 440.102). I also understand that a refusal to test under this circumstance will automatically result in forfeiture of my eligibility for medical and indemnity benefits and immediate termination from employment. I understand that a confirmed positive drug and/or alcohol test, a tampered with or an adulterated specimen or a refusal to test may result in forfeiture of unemployment benefits under Florida law.

I hereby give my consent to release the results of my blood urinalysis and/or breath test to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment. By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel/physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party. I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review Officer.

I also understand that the Drug -Free Workplace policy and related documents are not intended to constitute a contract between this employer and myself.

As an employee, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, and have received a written 60-day notification of this program, if applicable.

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

As a job applicant, I freely and voluntarily agree to a urinalysis drug screen as part of my application for employment and I understand that a refusal to test, a positive confirmed drug test or a tampered with or an adulterated specimen will disqualify me from employment, even if I have started work pending the results of the drug test. I understand I am still completing the application process and will not officially be an employee until the company receives a negative pre-employment drug test result. If I am employed by this company, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, as stated above.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Second Chance