**SECOND CHANCE AGREEMENT**

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**PURPOSE**: This document represents an agreement between COMPANY NAME and an employee. This document outlines the terms and conditions of COMPANY NAME’s **Second Chance Program**.

COMPANY NAME provides employees (and candidates) a “second chance…”

* after testing positive for drugs or alcohol, or
* if they self-disclose the need for treatment and are recommended for treatment following evaluation by a treatment specialist/qualified treatment provider (QTP).

As an alternative to termination of employment for violation of COMPANY NAME's Drug & Alcohol Use Policy, eligible employees may participate in the Second Chance Program, which provides them various forms of support provided they abide by and complete the treatment and recovery plan established by a qualified treatment provider.

**INSTRUCTIONS**: This form is to be provided to the employee by HR when one of the above conditions is met, along with other eligibility requirements for participation in COMPANY NAME’s **Second Chance Program**. This form should be provided to the employee as soon as possible. The employee will have X days to consider this agreement. The employee, the employee’s direct supervisor, and a representative of HR must sign this form.

This form, with the original signature, is to be retained by HR. HR will provide a copy to the employee and, if needed, members of the employee’s external treatment and recovery team. The employee’s direct supervisor will not receive a copy of this form, but it will be made available for viewing at request.

# PART 1: Employee Information

**INSTRUCTIONS:** To be completed by HR.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employee Name: |  | | |  | Department: |  |
| Job Title: |  | | |  | Employee ID: |  |
| Email Address: |  | | |  | Phone: |  |
| Meeting Date & Time: | |  | |  | Location: |  |
| HR Representative’s Name: | | |  |  | HR Job Title: |  |

# PART 2: Initiating Event

**INSTRUCTIONS:** To be completed by HR. Select which of the below is the basis for this agreement.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Employee voluntarily shared that they experience substance use or misuse issues or have addiction challenges.  Employee requested support through COMPANY NAME’s Second Chance Program.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Date request made: |  | |  | | | Request Made To (Name & Title): | |  | | |
|  | Employee voluntarily shared that they experience substance use or misuse issues or have addiction challenges.  Manager referred Employee to COMPANY NAME’s Second Chance Program.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Date request made: |  | |  | | | Request Made To (Name & Title): | |  | | |
|  | Employee tested positive for drugs or alcohol as part of a random selection drug and alcohol screen.   |  |  |  | | --- | --- | --- | | Date of Test: |  |  | |
|  | Employee tested positive for drugs or alcohol as part of a post-accident drug and alcohol screen.   |  |  |  |  | | --- | --- | --- | --- | | Date of Test: |  | Date of Accident: |  | |
|  | Employee tested positive for drugs or alcohol as part of a reasonable suspicion drug and alcohol screen.   |  |  |  | | --- | --- | --- | | Date of Test: |  |  | |
|  | Applicant tested positive for drugs during the pre-employment or selection/hiring process.   |  |  |  | | --- | --- | --- | | Date of Test: |  |  | |

Summarize the initiating event below. List any policies or workplace rules that were violated and any discipline issued.

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# PART 3: Second Chance Program Benefits & Support

**INSTRUCTIONS:** To be reviewed and understood by the employee.

Eligible, participating employees of COMPANY NAME’s Second Chance Program may receive the below benefits and support. The level of support and benefits received through the Second Chance Program will be determined based on the recommendation of the qualified treatment provider and other criteria as determined by COMPANY NAME. This may vary by individual.

I, , as an employee of COMPANY NAME and an eligible participant of the Second Chance Program, understand and may receive the following:

1. COMPANY NAME is committed to my health, safety, and well-being. This agreement is being offered to me as a demonstration of that commitment and as a tool to help support my treatment and recovery journey.
2. A custom treatment plan developed by my team of treatment specialists and medical professionals that may recommend services such as inpatient care (detox), a residential treatment program, outpatient care, counseling, group meetings, and more.
3. A custom recovery plan developed by my team of treatment specialists and medical professionals that may recommend services such as group meetings, peer coaches, individualized counseling, and more.
4. Company-sponsored health insurance coverage of some portion of the cost of evaluation and/or treatment (if currently insured and part of plan benefits).
5. Financial assistance from my employer to cover some of the cost of evaluation and/or treatment and recovery.
6. A communications plan that allows for ease of direct communication and information sharing between my employer and my treatment team.
7. A commitment to privacy and confidentiality by my employer regarding my participation in the Second Chance Program, my treatment plan, and my recovery plan. COMPANY NAME will make every reasonable effort to maintain my privacy and to protect my information.  This document and other related information may be shared with select, appropriate representatives of COMPANY NAME, including but not limited to my direct supervisor, my Return-to-Work Coordinator, and members of HR.
8. Continued ability to use my accrued paid time off for evaluation, treatment, or recovery.
9. Up to X hours of paid/unpaid time off to undergo evaluation and assessment (leave of absence).
10. Up to X hours of paid/unpaid time off to complete a treatment program (leave of absence).
11. Up to X hours of paid/unpaid time off to participate in recovery activities (leave of absence), such as support groups, counseling sessions, or mental health time off.
12. Up to X hours of wellness leave to undergo evaluation and assessment (active employment).
13. Up to X hours of wellness leave to complete a treatment program (active employment).
14. Up to X hours of wellness leave to participate in recovery activities (active employment), such as support groups, counseling sessions, or mental health time off
15. Family Medical Leave (if federally mandated conditions are met).
16. Support through COMPANY NAME’s Employee Assistance Program (EAP).
17. Support through COMPANY NAME’s Worker Peer Support Program.
18. A list of local support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).
19. A list of local treatment centers and specialists (Addiction Treatment Locator, Assessment & Standards Platform, or FindTreatment.gov).
20. Recovery coaching services (by phone).
21. A Return-to-Work Plan that will assist with my transition back to the workplace.
22. Job or worksite accommodations and adjustments as appropriate, reasonable, and determined by my qualified treatment provider, supervisor, and HR.
23. Guarantee that a position remains available upon my return to work.  This may or may not be the exact position I was in previously.
24. Short-term disability insurance coverage that provides some salary replacement while I am out for treatment.
25. Continued opportunity to advance my career without judgment or discrimination.

# PART 4: Requirements for Participation in the Second Chance Program

**INSTRUCTIONS:** To be reviewed and understood by the employee.

I,       (employee name), as an employee of COMPANY NAME, have been informed that:

1. My continued eligibility to participate in COMPANY NAME’s Second Chance Program depends on the recommendation of a yet-to-be-determined QTP. I understand that should the QTP find that I do not require treatment, my participation in this program may be denied/revoked. My QTP will determine the duration of my treatment and recovery plans.
2. My participation in this program may be an alternative to termination, and termination could still result for other reasons or pending outcome of any current or future investigations or newly discovered facts surrounding the event that led to program participation.
3. This Agreement is contingent upon my continued participation in, adherence to, and completion of the treatment plan, recovery plan, and return-to-work plan established by my QTP (and, in some cases, employer). My failure to fully participate, complete, or adhere to my treatment or recovery plan may lead to termination, discipline, or program removal.
4. Regardless of my participation in the Second Chance Program, I remain subject to the same rules, working conditions, and disciplinary procedures as other employees. I agree to comply with all company rules, policies, practices, and procedures and understand that this agreement in no way prevents my employer from taking disciplinary action, including termination or revoked eligibility for participation in this program, for violations, performance, or conduct issues. I remain an at-will employee.
5. I must sign this agreement within X days of receipt.
6. I must schedule an evaluation/assessment with a QTP within X days of receipt of this contract.
7. If my QTP recommends, I will have X days to enter a substance addiction treatment program, receive inpatient care, outpatient care, etc.
8. My QTP will regularly inform COMPANY NAME, as my employer, of the status of my participation in treatment and recovery activities and adherence to my treatment and recovery plans. I must authorize my qualified treatment provider and my employer to share information about the status of my participation in treatment and recovery activities and adherence to my treatment and recovery plans. I am required to sign the Consent to Share Information form and may be required to sign other related documents.
9. I may be required to provide status updates to my employer, submit proof of plan adherence (which could take various forms), and secure signatures or slips from individuals on my care team. I may be required to document attendance at mandatory appointments and other required appearances.
10. This agreement will remain in effect until the end date established on my RTW Plan. If I do not require a RTW Plan, this date will be determined by my QTP, other treatment team members, and employer.
11. It is my responsibility to inform COMPANY NAME of my specific needs or to seek out any additional help that I require to help me complete my treatment, recovery, or return-to-work plans. COMPANY NAME may not be required to fulfill my requests. I am responsible for working with my QTP and employer to adjust those plans as needed and sharing adjustments with all parties.
12. I will be subject to drug & alcohol testing upon request and without warning for X years from the date of this signed agreement.
13. A positive test may require a follow-up evaluation with a QTP or other treatment specialist and/or result in employment termination, revoked eligibility for program participation, or other consequences.
14. I am responsible for my evaluation, treatment, and recovery costs. My company-sponsored insurance may or may not cover some of the costs, and my employer may or may not provide direct financial assistance.
15. I am responsible for proactively and regularly working with HR to better understand and utilize the benefits available to me and how to use such benefits. This includes utilizing paid and unpaid leave – such as sick leave, vacation leave, personal leave, wellness leave, FMLA, unpaid leave of absence, paid leave of absence, and more -- to attend evaluation, treatment, and recovery activities.
16. I will abstain from alcohol and/or other drugs except when prescribed by a physician informed of my history of substance use/misuse and addiction issues.
17. Should relapse occur, I will notify my QTP immediately. Should relapse result in use or impairment while on the job, I will notify my QTP and employer immediately.
18. I understand that relapse could result in ineligibility to continue participating in the Second Chance Program and represent a breach of contract for this Second Chance Agreement. I may not receive another Second Chance Agreement. My employer may evaluate the circumstances under which I relapsed, the length of my sobriety, my work performance, recommendations from my QTP and other service providers engaged in my treatment and recovery plan.
19. This document and all associated records will be linked to my personnel file and maintained according to the company’s records retention standards.
20. I understand that COMPANY NAME assumes no responsibility for the drug or alcohol rehabilitation of any employee.

# PART 5: Employee Signature

My signature and selection of one of the options below represents my acceptance or rejection of this agreement and all it entails. Should I accept the terms of this agreement, this contract goes into effect upon my signing. If I fail to select one of the options below or to sign, it will be treated as a rejection of this agreement. A rejection of this agreement will represent a tendering of my resignation, and my employment will not continue, effective immediately.

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| --- | --- |
|  | I opt to participate in COMPANY NAME’s Second Chance Program and abide by all herein this agreement. |
|  | I decline to participate in COMPANY NAME’s Second Chance Program. I understand that not participating in the program means I am resigning immediately. |
|  | HR USE ONLY: Employee refused or failed to sign this document by the above deadline. |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name (Print): | | | | | |  | | |
| Employee Signature: | | | | |  | | | |
| Date: | |  | | | | | | |
| Supervisor Name (Print): | | | | | | |  | |
| Supervisor Signature: | | | | |  | | | |
| Date: |  | | | | | | | |
| HR Representative Name (Print): | | | | | | | |  |
| Job Title: | | |  | | | | | |
| Signature: | | | |  | | | | |
| Date: | |  | | | | | | |