**RETURN TO WORK AGREEMENT**

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**PURPOSE**: This agreement between COMPANY NAME and an employee participating in COMPANY NAME’s Second Chance Program outlines the plan for the employee once they return to work following a treatment-related absence. The plan includes the responsibilities of the employer and the employee to help ensure the employee successfully reintegrates into the workplace and can continue their treatment and recovery journey.

**INSTRUCTIONS**: This form is to be provided to the employee by HR before the employee’s return to work following a treatment-related absence as part of the Second Chance Program. The employee may not return to work until:

* authorized to do so by their QTP
* completing an alcohol and/or drug screen with negative results and
* signing this agreement.

This agreement is an essential guiding document and should be shared with the employee’s direct supervisor and all others who will support the employee on their treatment and recovery journey. HR will partner with the employee’s qualified treatment provider (QTP) and other members of the treatment team to customize this agreement.

This form, with the original signature, is to be retained by HR. HR will provide a copy to the employee and, if needed, give the employee’s designated QTP or other treatment team member a copy.

# PART 1: Employee Information

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name: |  | |  | | Department: | |  | |
| Job Title: |  | |  | | Employee ID: | |  | |
| Email Address: |  | |  | | Phone: | |  | |
| Dates of Leave: |  | | |  | | Return to Work Date: | |  | |
| RTW Plan Start Date: | |  |  | | RTW Plan End Date: | |  | |

# PART 2: Employer Information

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Supervisor Name: |  |  | | Job Title: | |  | |
| Email Address: |  |  | | Phone: | |  | |
| RTW Coordinator: |  |  | | Job Title: | |  | |
| Email Address: |  | |  | | Phone: | |  | |

The below individuals – employees, partners, vendors, and customers of COMPANY NAME – may have input into the employee’s progress and may provide information that will alter the RTW plan:

|  |  |  |
| --- | --- | --- |
| Name |  | Job Title |
|  |  |  |
|  |  |  |
|  |  |  |

The below individuals – employees, partners, vendors, and customers of COMPANY NAME – may be informed of Employee’s participation in COMPANY NAME’s Second Chance Program but will not have input into Employee’s progress or provide information that will alter the RTW plan:

|  |  |  |
| --- | --- | --- |
| Name |  | Job Title |
|  |  |  |
|  |  |  |
|  |  |  |

# PART 3: Initiating Event

**INSTRUCTIONS:** To be completed by HR. Select which of the below led to participation in COMPANY NAME’s Second Chance Program, as indicated in this employee’s Second Chance 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: |  |  | |

# PART 4: Second Chance Program Benefits & Support

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

Eligible, participating employees of COMPANY NAME’s Second Chance Program are subject to and must abide by the below requirements to continue participation in the program during their Return-to-Work period, as outlined below.

I, EMPLOYEE NAME, as an employee of COMPANY NAME, understand the following:

1. This RTW Plan represents an agreement between my employer and me to assume the responsibilities outlined in this document. This does not represent a promise of continued employment. I remain an at-will employee and am subject to the same performance and conduct standards as all other employees. My employment can be terminated at any time.
2. My employer and my treatment team supply the details of this RTW Plan. My employer is the author of this agreement. This agreement is subject to change and will be updated by my employer periodically throughout said agreement.
3. 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 update the Consent to Share Information form as needed.
4. 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.
5. 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 the above plans may lead to termination, discipline, or program removal. I understand my recovery and RTW plans may include participation in aftercare programs, support groups, individual counseling, EAP, practicing appropriate and relevant self-care, establishing a relapse prevention plan, and more.
6. I am responsible for informing COMPANY NAME of my specific needs or seeking any additional help I require to help fulfill return-to-work plan requirements. COMPANY NAME may not be required to satisfy my requests. I am responsible for working with my QTP and employer to adjust my plan and share adjustments with all parties.
7. I agree to communicate to my QTP and supervisor any concerns regarding my recovery related to workplace circumstances or other aspects of my employment.
8. I will meet with my RTW Plan Coordinator and/or supervisor, as outlined below, to provide updates to this plan.
9. 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.
10. 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.
11. 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.
12. Going forward, I will disclose my treatment and recovery plan to all medical personnel upon receiving any substance that could compromise my sobriety.
13. I will be subject to drug & alcohol testing upon request and without warning for X years from the date of this signed agreement.
14. 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.
15. 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, members of HR, and other parties.
16. I must sign this agreement within X days of receipt. I am not permitted to return to work until this agreement is signed.
17. This agreement will remain in effect until X.

# PART 5: Employer Acknowledgement

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

1. If eligible and necessary, COMPANY NAME will provide Employee with reasonable accommodation in accordance with company policy and the ADA.
2. COMPANY NAME will consider providing Employee with reasonable work adjustments that do not result in a significant hardship.
3. COMPANY NAME will provide Employee’s direct supervisor and others with access to information and resources regarding substance use disorder, treatment plans, the recovery journey, and more to help educate, build awareness, and skill-build.
4. Employee’s direct supervisor will follow the guidance set forth through company policy, agreement, education, and information-sharing to create a high-trust, supportive environment, free from stigma, harassment, and discrimination, to the best of their ability and is reasonable.
5. Your RTW Plan Coordinator and/or direct supervisor will meet with you to discuss plan updates, as outlined below.

# PART 6: Return to Work Plan Detail

**INSTRUCTIONS:** To be completed by the employer, employee, and treatment team. To be updated periodically, as needed.

|  |  |  |  |
| --- | --- | --- | --- |
|  | RETURN-TO-WORK GOAL | Permanent | Temporary (dates) |
|  | Return to job with no special support, adjustment, or accommodation requests. |  |  |
|  | Return to job with support and adjustment. |  |  |
|  | Return to job with accommodation. |  |  |
|  | Return to alternate work.  Alternate job description attached?  Yes or  No |  |  |

Original job description attached?  Yes or  No

If (2) is selected above, briefly describe the desired support and adjustment below. Detail if adjustment is needed for duties, workspace/environment, and/or work schedule. If temporary, list the expected duration.

If (3) is selected above, briefly describe the desired accommodation below. Detail if accommodation is needed for duties, workspace/environment, and/or work schedule. If temporary, list the expected duration.

If (4) is selected above, briefly describe the desired alternate work of the attached job description. If temporary, list the expected duration.

Please explain below if you cannot perform previous job responsibilities, tasks, and/or core competencies. Attach any relevant documentation, such as job description, competency list, required skills, etc.

Click or tap here to enter text.

Does Employee require a modified work schedule?  Yes or  No

If yes, select which of the below apply:

|  |  |
| --- | --- |
|  | Reduced-hour work schedule |
|  | Part-time work schedule |
|  | Flexible start and end times |
|  | Flexible break schedule |
|  | Remote/off-site |

If yes to reduced hours or part-time, how will Employee be compensated?

Click or tap here to enter text.

What is the proposed work schedule, and how does it vary from the existing work schedule?

Click or tap here to enter text.

# PART 7: RTW Plan Follow-up Schedule

**INSTRUCTIONS:** Employee will regularly meet with their RTW Plan Coordinator and/or supervisor throughout this plan. These meetings aim to review plan progress and discuss necessary adjustments. The HR Representative or RTW Coordinator should fill in this section.

|  |  |
| --- | --- |
| Meetings will occur (frequency): |  |
| Meetings will begin: |  |
| Participants include: |  |
| Meeting location: |  |
| Party responsible for scheduling: |  |
| Employee is required to bring the following to meetings: |  |

# PART 8: Employee Signature

My signature and selection of one of the options below represents my acceptance or rejection of this agreement and all that 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.

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

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