

California State University, Long Beach Research Foundation

Memorandum

TO: CSULB Research Foundation Employees
FROM: Human Resources Department
SUBJECT: Drug-Free Workplace Policy

In accordance with the Drug-Free Workplace Act of 1988 (41 U.S.C. § 701 et. seq.), the California State University, Long Beach Research Foundation (Research Foundation) has established the following policy:

Due to the prevalent use of illegal drugs in the United States and the hazards they pose in the workplace, not only to the abuser but to the general population as well, the Research Foundation strictly prohibits the manufacture, sale, purchase, offer to sell or purchase, distribution, use, dispensation or possession of illegal drugs in the workplace. Physician-prescribed medications may be used by employees, provided the drugs do not adversely affect job performance or the safety of the employee or other individuals in the workplace.

It is the responsibility of any Research Foundation employee convicted of a criminal drug offense occurring in the workplace to notify the Research Foundation Human Resources Department within five (5) calendar days of conviction. Action may be taken against any Research Foundation employee convicted of a criminal drug offense occurring in the workplace. Appropriate action may include discipline, up to and including termination, and/or the requirement of satisfactory participation in a drug treatment program as deemed necessary by the Research Foundation Chief Operating Officer or his designee.

To further enhance this effort, a drug-free awareness program has been established to inform Research Foundation employees of the dangers of drug abuse in the workplace, and the availability of drug counseling and rehabilitation programs. This program is designed to assist all Research Foundation employees. Any employee who wishes further information should contact the Research Foundation Human Resources Department at (562) 985-7950.

Employee Acknowledgment

I understand compliance with the above policy is a condition of my employment with the CSULB Research Foundation, and I agree to abide by the above policy.

Employee Name (printed) _____

Employee Signature _____ Date _____

**Please complete and return this form to: CSULB Research Foundation Human Resources Department
6300 State University Drive, Suite 332
Long Beach, CA 90815**

VOLUNTARY SELF-IDENTIFICATION OF DISABILITY

Form CC-305

OMB Control Number 1250-0005

Page 1 of 1

Expires 05/31/2023

Name: _____

Date: _____

Employee ID: _____
(if applicable)

WHY ARE YOU BEING ASKED TO COMPLETE THIS FORM?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

HOW DO YOU KNOW IF YOU HAVE A DISABILITY?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

PLEASE SELECT ONE BELOW

Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

No, I Do Not Have A Disability, Or A History/Record Of Having A Disability

I Do Not Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

FOR EMPLOYER USE ONLY

ADS Updated By: _____

Date: _____