Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
Phone: 615-532-1321 FAX: 615-253-5265 Email: DFW.Program@tn.gov
https://www.tn.gov/workforce/injuries-at-work/employers/employers/drug-free-workplace-program.html

DRUG FREE WORKPLACE PROGRAM APPLICATION

1. **This application must be complete, legible and signed or it will be RETURNED.**
2. **This application must be resubmitted anytime the employer changes insurance carriers.**
3. **This form must be submitted to the Bureau. Please include the completed original copy of this form plus one photocopy, a copy of PROOF OF COVERAGE and two pre-addressed, stamped envelopes:**
   a. **One addressed to your Workers' Compensation Insurance Carrier and**
   b. **One addressed to the employer named below.**
4. **THIS APPLICATION MUST BE RENEWED ANNUALLY.**

Check One: **New application** ☐ **Renewal application** ☐ **Changed Insurance Carrier** ☐

Company Name _____ FEIN: _____

Mailing Address _____ City _____ State & Zip _____

Business Address _____ City _____ State & Zip_____

Primary Contact (Name and Title) _____/_____

Phone #_____ Fax #_____ Email _____

Nature of Business _____ Total # of FT & PT employees_____

Workers' Compensation Insurance Carrier _____

Lab Certification (circle one): **SAMHSA CAP-FUDTAP Other** _____

Name of Testing Laboratory _____City _____State_____ ZIP _____

Name of Medical Review Officer (MRO)_____ Phone # _____

Have all employees hired prior to the date of this application been provided at least one hour of substance abuse training? Yes ☐ No ☐

Have all employees hired prior to the date of this application been informed of your company's drug free program policies? Yes ☐ No ☐

Effective date of your program _____

Renewal applicants only:

Number of tests performed in past 12 months for each of the following:

Job Applicants: Total_____ Positive _____ Routine Fitness for Duty: Total_____ Positive _____

Post work accident: Total _____ Positive _____ EAP Follow-up: Total _____ Positive _____

Random (optional): Total _____ Positive _____ Reasonable Suspicion Total _____ Positive _____

Have all employees that have undergone substance abuse training acknowledged, in writing, their attendance at that training and the existence of your company's drug free program policies? Yes No

I hereby certify that all provisions and requirements of the Tennessee Drug-Free Workplace Program as established by T.C.A. have been met and implemented. (To be signed by all applicants)

_____

Owner/Officer's Signature and title Printed name Date

_____

Bureau of Workers' Compensation Representative Signature Title Accepted Date