



Tennessee Bureau of Workers' Compensation
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Email: DFW.Program@tn.gov

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 a participating employer **purchases or renews** their workers' comp policy.
3. This form must be submitted to the Bureau by email, fax, or mail. If mailed, **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 _____ Title _____

Phone # _____ Fax # _____ Email _____

Nature of Business _____ Total # of FT & PT employees _____

Workers' Compensation Insurance Carrier _____

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

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 Printed name Title Date

Bureau of Workers' Compensation Representative Signature Title Accepted Date