

- APPLICATION -

**TENNESSEE DRUG-FREE WORKPLACE
PREMIUM CREDIT PROGRAM**

<p>TENNESSEE DRUG FREE WORKPLACE</p>

Directions: This form should be completed by the employer and must be signed by an owner/officer of the company. After reading and understanding the Rules & Guidelines for Participating Employers (Chapter 0800-2-12), please answer all questions that apply. Please refer to the Additional Instructions located on the back of this form before submitting this application.

Important: Keep a copy of this form for your records! Employers should properly document their compliance with the Rules & Guidelines established for participation in the Tennessee Drug-Free Workplace Program. You may be asked to supply documentation to support your compliance by the Tennessee Department of Labor and Workforce Development when denying workers' compensation benefits to an employee pursuant to provisions of the Tennessee Drug-Free Workplace Program, (Tennessee Code Annotated, Section 50-9-100 et. seq.).

I. Type of Report: (check one)

_____ Initial/first time application _____ Renewal application for _____ Rescission/Termination of
for Premium Credit Program Premium Credit Program participation by employer

II. Applicant Information: (complete for all applications; if necessary, please list additional locations on a separate sheet and attach it to this form)

Company Name: _____ FEIN: _____

Mailing Address: _____

Nature of Employer's Business: _____ Number of Full-time & Part-time employees: _____

Effective date of your program: _____ / _____ / _____ Date Written Policy Statement Posted Or Provided To All Employees: _____ / _____ / _____

Name of Workers' Compensation Insurance Co: _____

Mailing Address of Insurance Company: _____

Name Of Substance Abuse Program Administrator, (If Used): _____ City, State: _____

III. Drug Testing Program: (complete for all applications)

Name Of Drug Testing Laboratory: _____ City, State: _____

Name Of Medical Review Officer: _____ City, State: _____

Lab Certification: SAMSHA: _____ CAP-FUDTAP: _____ Other: _____ Phone: _____

Number Of Tests Performed In Past 12 Months For Each? (Optional For Initial/First-Time Applications, Required For All Other Applications)

Job Applicants _____ Routine Fitness For Duty _____ Reasonable Suspicion _____

Follow-Up To EAP _____ Post-Accident _____ Random (Optional) _____

IV. Education And Employee Assistance Program: (Complete For All Applications)

Please provide the date or dates you conducted, or plan to conduct, an annual minimum two-hours of workplace Substance Abuse Recognition training for supervisory personnel: _____ / _____ / _____ ; _____ / _____ / _____

Please provide the date you conducted, or plan to conduct, an annual minimum one-hour of a workplace Substance Abuse Education and Awareness Program for all your employees: _____ / _____ / _____

Are employees required to use a designated employee assistance program for substance abuse treatment? Yes ___ No ___

If yes, how many of your employees used it for substance abuse treatment in the past 12 months? _____

If no, do you maintain & post a list of local employee assistance programs or substance abuse treatment centers? Yes ___ No ___

V. Existing Substance Abuse Program: (Optional, Complete Only If You Had A Substance Abuse Program In Place Previous To This Application)

Date Previous Program Began: _____ / _____ / _____ If You Provided A Designated Employee Assistance Program, How Many Employees Used It For Substance Abuse In The Past 12 Months? _____

Name Of Drug Testing Laboratory: _____ City, State: _____

Name Of Medical Review Officer: _____ City, State: _____

Lab Certification: SAMSHA: _____ CAP-FUDTAP: _____ Other: _____ Phone: _____

Number Of Tests Performed In Past 12 Months For Each?:

Job Applicants _____ Routine Fitness For Duty _____ Reasonable Suspicion _____

Follow-Up To EAP _____ Post-Accident _____ Random (Optional) _____

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VI. Additional Instructions:

All applications for certification of your Drug-Free Workplace Program must be mailed to the Tennessee Department of Labor & Workforce Development address given below, (faxed applications WILL NOT be accepted), and must include the following items; (1) the completed original copy of this form AND one photocopy of the completed original form, and (2) a self-addressed, stamped "number 10" return envelope listing the mailing address of your Workers' Compensation Insurance Company or the Insurance Agent of Record for your Workers' Compensation policy. Anytime an employer who is currently receiving the premium credit changes carriers for their Workers' Compensation Coverage, the above items, (1) & (2), must be resubmitted to the Tennessee Department of Labor & Workforce Development.

If an employer is a member of a *Self-Insured Workers' Compensation Pool Program* the above items (1) & (2) should be mailed to the Tennessee Department of Labor & Workforce Development address given below, (faxed applications WILL NOT be accepted), with a self-addressed, stamped "number 10" return envelope listing the mailing address of your pool program's administrative office.

Employers who are *Totally Self-Insured for Workers' Compensation Benefits* must mail the above items (1) & (2) to the Tennessee Department of Labor & Workforce Development address given below, listing the mailing address for the department or person at your company who is responsible for the administration of your Drug-Free Workplace Program on the self-addressed, stamped "number 10" return envelope.

Renewals - In order to continue to receive the premium credit for each subsequent policy year, the application must be renewed annually. A new copy of this form must be completed by the employer at the anniversary date of their Workers' Compensation policy. The same mailing procedures mentioned above must be followed; no other information is necessary.

Termination of Program - Anytime an employer wishes to terminate his/her participation in the Drug-Free Workplace Program, a new copy of this form must be completed and mailed to the Tennessee Department of Labor & Workforce Development. The mailing procedures mentioned above must be followed.

VII. Penalties for Misrepresentation of Compliance:

If an employer misrepresents compliance, however, with his/her certified drug-free workplace program, the employer shall be subject to an additional premium for purposes of reimbursement of a previously granted discount. (T.C.A. Section 50-6-418)

If an employer has made a good faith effort to fulfill certain criteria for certification, however, this good faith effort will be taken into consideration when determining whether the employer has complied substantially with certification criteria.

Remember, this is a voluntary program, and your participation is not required by law!

VIII. Employer Certification: (complete for all applications)

I hereby certify that all provisions and requirements of the Tennessee Drug-Free Workplace Program as established by T.C.A. Sections 50-9-100 et. seq. have been met and implemented. I have read and do understand the Penalties for Misrepresentation of Compliance.

Owner/Officer's Signature & Title	Name in Print	Date
Owner/Officer's Address		Phone Number

Mail directly to:

Tennessee Department of Labor &
Workforce Development
Division of Workers' Compensation
Drug-Free Workplace Program
710 James Robertson Pkwy, 2nd Floor
Nashville, TN 37243-0661

COMMISSIONER	
Tennessee Department of Labor & Workforce Development	DATE RECEIVED

The Tennessee Department of Labor & Workforce Development is committed to the principles of equal opportunity and equal access. Alternative print copies of this form are available, call: (TDD) 1-800-332-2667.

NCCI ID # _____

Comments or Questions about the Tennessee Drug-Free Workplace Program? Please call: 1-800-332-2667, (during regular hours).
