

**FFVA MUTUAL INSURANCE CO.
APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM**

This form should be completed by the Employer and must be signed by an owner/officer of the company. After reading and understanding the Drug-Free Workplace Workers' Compensation Premium Reduction Act (Mississippi Code Ann. § 71-3-201 through 71-3-225) Please answer all questions that apply. Annual certification is required.

Name of Employer: _____ phone number: _____

Date Program Implemented: _____ Program contact email address: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- | | |
|---|---|
| <input type="checkbox"/> Job applicant | <input type="checkbox"/> Routine fitness for duty |
| <input type="checkbox"/> Reasonable suspicion | <input type="checkbox"/> Follow-up testing to Employee Assistance Program |

Notice of Employer's Drug Testing Policy:

- | | |
|--|---|
| <input type="checkbox"/> Copy to all employees prior to testing | <input type="checkbox"/> Show notice of drug testing on vacancy announcements |
| <input type="checkbox"/> Posted on employer's premises | <input type="checkbox"/> Copies available in personnel office or other suitable locations |
| <input type="checkbox"/> Copy to job applicants prior to testing | |

Education and Employee Assistance Program: (Required on all applications.)

Please provide the date you conducted or plan to conduct an annual minimum two-hour 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 Workplace Substance 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 **no**, do you maintain & post the required list of local employee assistance programs or substance abuse treatment centers? **Yes () No ()**

Drug Testing Program: (Required on all applications.)

Name of Testing Laboratory _____ City, State _____

Name of Medical Review Officer (MRO) _____ City, State _____

Lab Certification: **SAMHSA** _____ **CAP-FUDTAP** _____ **Other** _____ **MRO Phone** _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Mississippi law.

The under-signed certifies that the employer's anti-drug program contains a written policy statement, which sets forth the employer's policy against drug use in the work place, which advises employees of the existence of the Drug-Free Workplace Workers' Compensation premium Reduction Act, which addresses confidentiality, which advises employees of the availability of assistance through an internal or external assistance programs, and which informs employees about the Federal Drug Free Workplace Act, if applicable to employer.

Owner/Officer's Signature & Title

Name in Print

Date