I, _____, in my capacity
(Name)
as _____ , attest that the
(Title)
Drug-Free Workplace Policy for _____
(Company Name)
has not changed since the last certification by the Department of Industrial Relations, Workers' Compensation Division, on _____.
(Date of Previous Certification)

OR

I, _____, in my capacity
(Name)
as _____ , attest that the
(Title)
Drug-Free Workplace Policy for _____
(Company Name)
has changed since the last certification by the Department of Industrial Relations, Workers' Compensation Division, on _____. A copy
(Date of Previous Certification)
of the new/revised policy is attached for review by the Workers' Compensation Division.

Notarization of Certified Drug-Free Workplace Program

_____ _____
Employer Name Officer/Owner Signature*

_____ _____
Date Title of Officer/Owner

* **Application must be signed by an officer or owner.**

Sworn to and subscribed before me this _____ day of _____ 20___

_____
Notary Public

My Commission Expires: _____