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
http://www.tn.gov/workforce/article/drug-free-workplace-program

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.**

Circle one: **New application** **Renewal application** **Changed Insurance Carrier**

Company Name _____ FEIN: _____

Mailing Address _____ City _____ State & Zip _____

Business Address _____ City _____ State & Zip_____

Phone #_____ Fax #_____ Email _____

Name of Substance Abuse Program Administrator _____

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