



TENNESSEE DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM APPLICATION

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 and Guidelines for Participating Employers (Chapter 0800-2-12) please answer all questions that apply. You may also refer to the Additional Instructions section located on the back of this form before submitting this application.

Date Application Received _____

Departmental Use Only

Important: All applications must be complete, legible and signed or they will be returned. Copies will not be accepted. Include the completed original copy of this form plus one photocopy of the completed form, a copy of proof of coverage and a self-addressed, stamped #10 envelope addressed to your Workers' Compensation Insurance Carrier or Agent of Record for your workers' compensation policy. Keep a copy of this form for your records.

Part A - Type of Form (check one): New Application () Renewal () Termination/Rescission ()

Part B - Applicant Information:

I. Company Name _____ FEIN: _____
 Mailing Address _____ City _____ State & Zip _____
 Phone # _____ Fax # _____
 Email address _____
 Nature of Business _____ Number of Full-time & Part-time Employees _____ / _____
 Workers' Compensation Insurance Carrier _____
 Mailing Address _____ City _____ State & Zip _____
 Name of Substance Abuse Program Administrator _____
 Date written policy statement was provided to all employees ____/____/____ Effective date of your program ____/____/____

II. 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:** _____

III. 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 **yes**, how many of your employees used it for substance abuse treatment in the past twelve 12 months? _____
 If **no**, do you maintain & post the required list of local employee assistance programs or substance abuse treatment centers? **Yes () No ()**

Part C - Renewal Applicants Only:

IV. Date Previous Program Began ____/____/____ How many employees used it for substance abuse treatment in the past 12 months? _____
 Name of Testing Laboratory _____ City, State _____
 Name of Medical Review Officer (MRO) _____ City, State _____
 Lab Certification: **SAMHSA** _____ **CAP-FUDTAP** _____ **Other** _____ **MRO Phone:** _____
Number of tests performed in past 12 months for each of the following:
 Job Applicants: Positive ____ Total ____ Routine Fitness for Duty: Positive ____ Total ____ Post work accident: Positive ____ Total ____
 EAP Follow-up: Positive ____ Total ____ Reasonable Suspicion: Positive ____ Total ____ Random (optional): Positive ____ Total ____

Part D - Termination / Rescission of Participation by Employer:

V. Date Previous Program Began ____/____/____ How many employees used it for substance abuse treatment in the past 12 months? _____
Number of tests performed in past 12 months for each of the following:
 Job Applicants: Positive ____ Total ____ Routine Fitness for Duty: Positive ____ Total ____ Post work accident: Positive ____ Total ____
 EAP Follow-up: Positive ____ Total ____ Reasonable Suspicion: Positive ____ Total ____ Random (optional): Positive ____ Total ____
 Reason for Termination / Rescission _____

