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 ☐ Changed Ins Carrier ☐

Part B-Applicant Information:

I. Company Name_____FEIN:_____

Mailing Address_____City_____State & Zip_____

Business 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 Quest Diagnostics City, State_____

Name of Medical Review Officer (MRO) Dr. John Saler City, State Dickson, TN

Lab Certification: **SAMHSA** X **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_____

VI. Additional Instructions

All applications for the Tennessee Drug-Free Workplace Program must include (1) the completed original copy of this form plus one photocopy of the completed form, (2) a copy of proof of coverage and (3) a self-addressed, stamped #10 envelope addressed to your Workers' Compensation Insurance Carrier or Agent of Record for your workers' compensation policy. Applications must be mailed to the Department of Labor and Workforce Development at the address indicated below. Anytime an employer who is currently receiving the premium credit changes carriers for their Workers' Compensation Insurance, items (1), (2) and (3) must be resubmitted to the Department of Labor and Workforce Development.

If an employer is a member of a *Self-Insured Workers' Compensation Pool Program* or is *Totally Self-Insured for Workers' Compensation Coverage*, items (1), (2) and (3) should be mailed to the Department of Labor and Workforce Development according to the instructions above, with a self-addressed, stamped #10 envelope addressed to either your pool program's administrative office or the department or person at your company who is responsible for the administration of your Drug-Free Workplace Program.

Keep a copy of this form for your records. Employers should properly document their compliance with the Rules and Guidelines established for participation. You may be asked to supply documentation to support your compliance when denying workers' compensation benefits to an employee pursuant to the provision of the Tennessee Drug-Free Workplace Program (50-9-100 et. seq.). There will be a charge for additional copies of an employer's Tennessee Drug-Free Workplace Application. All requests must be in writing on your company's letterhead and submitted via facsimile at 615-532-1468. Billing will be done on a monthly basis.

Renewals – In order to continue to receive the premium credit for each subsequent policy year, THIS APPLICATION MUST BE RENEWED ANNUALLY. By the anniversary date of their Workers' Compensation insurance policy, a new copy of this form must be completed by the employer and submitted with items (1), (2) and (3). Applications must be mailed to the Department of Labor and Workforce Development at the address indicated below.

Termination/Rescission of Program – Any employer who wishes to terminate their participation in the Tennessee Drug-Free Workplace Program must provide a new completed copy of this form to the Department of Labor and Workforce Development according to the instructions above.

Applications, Renewals and Terminations are not accepted by facsimile.

VII. Penalties for Misrepresentation of Compliance

An Employer who misrepresents compliance with their Tennessee Drug-Free Workplace Program shall be subject to an additional premium for purposes of reimbursement of any previously granted discount. (T.C.A. Section 50-6-418)

An Employer's good-faith effort to fulfill certain criteria for certification will be taken into consideration when determining whether the Employer has complied substantially with certification criteria.

VIII. Employer Certification: (Required on 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 Mailing Address | Phone Number

Mail Directly to:
Tennessee Department of Labor & Workforce Development
Division of Worker's Compensation
Drug-Free Workplace Program
220 French Landing Drive
Nashville, TN 37243-1002

Commissioner or his designee, DRUG-FREE WORKPLACE PROGRAM
Tennessee Department of Labor & Workforce Development DATE ACCEPTED

The Tennessee Department of Labor & Workforce Development is committed to the principles of equal opportunity and equal access.

For comments or questions regarding the Tennessee Drug-Free Workplace Program or for alternative print copies of this form, call: 1-800-332-2667 (TDD) during regular business hours.
Or visit our website at www.state.tn.us/labor-wfd/dfwp.html

NCCI ID#