



Application for Drug-Free Workplace Program and Drug-Free EZ

INSTRUCTIONS:

- Please print or type.
- You may submit the completed form in one of three ways:
 Online – www.ohioabc.com
 Fax – (614) 728-3205
 Mail – Attention: Risk Special Programs, 22nd Floor
 Ohio Bureau of Workers' Compensation
 30 W. Spring St.
 Columbus, OH 43215-2256

Name of employer and DBA		BWC policy number	Federal Tax ID number
Address	City	State	ZIP code
E-mail address	FAX number ()	Telephone number ()	
Employer contact person for Drug-Free Workplace Program (DFWP) or Drug-Free EZ Program (DF-EZ)		Telephone number ()	

NOTE:

BWC must receive a completed application, signed by a designated employer representative, by June 30 for the program year beginning July 1, or by Dec. 31, for the program year beginning Jan. 1. Incomplete applications will be rejected.

Employers who have, on an average, 25 or fewer employees will participate in DF-EZ Program.

Check Program Period applied for: <input type="checkbox"/> July 1 – June 30 <input type="checkbox"/> Jan. 1 – Dec. 31	Check the drug-free program level for which you are requesting approval: <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Comparable program
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Is this application being submitted by a contractor or subcontractor in relationship to a State of Ohio construction contract? Yes
 No

Personnel [include all permanent full time, part time, and intermittent/seasonal]	Number of employees _____	
Do you have an existing substance-free workplace program that has been in place for one or more years? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, on what date did your program begin? _____		
<p>I hereby certify that my organization is applying to implement a DFWP or DF-EZ Program pursuant to Rule 4123-17-58 or 4123-17-58.1 of the Ohio Administrative Code and is willing to meet, at minimum, the requirements associated with the level of program applied for. When failing to fully implement the DFWP or DF-EZ Programs or meet the specified requirements, I agree to repay to the Ohio Bureau of Workers' Compensation any DFWP or DF-EZ Program discount received. Also, I certify this information is accurate and, if not, may be considered a fraudulent representation which may lead to legal action under the applicable fraud statutes.</p>		
Name of designated employer representative	X Signature	Date signed