

**NOTICE TO EMPLOYER:** If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

**APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM**

Name of Employer: \_\_\_\_\_

Date Program Implemented: \_\_\_\_\_

**Testing:**

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- Job applicant
- Reasonable suspicion
- Routine fitness for duty
- Follow-up testing to Employee Assistance Program

**Notice of Employer's Drug Testing Policy:**

- Copy to all employees prior to testing
- Posted on employer's premises
- Copy to job applicants prior to testing
- General notice given 60 days prior to testing
- Show notice of drug testing on vacancy announcements
- Copies available in personnel office or other suitable locations
- No notice required because the employer had a drug testing program in place prior to July 1, 1990

**Education:**

- Resource file on providers
- Employee Assistance Program
- Education

Name of Medical Review Officer: \_\_\_\_\_

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: \_\_\_\_\_

B. Phone No.: (        ) \_\_\_\_\_

C. Address: \_\_\_\_\_

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ Employer Name	_____ Date	_____ Officer/Owner Signature*
		_____ Title

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

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

_____ Notary Public's Signature	_____ Date	_____ Expiration of Commission
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