

**THIS APPLICATION / AFFIDAVIT MUST BE SUBMITTED TO THE
DEPT. OF WORKERS' CLAIMS**

Application can be sent via email to: Tara.Aziz@ky.gov

Or by mail to:

Dept. of Workers' Claims

Attn: Tara Aziz - Drug Free Workplace Program Coordinator

Mayo Underwood Building

500 Mero St. 3rd Floor

Frankfort, KY 40601

Phone: 502-564-5550

Part A: Type of Form (check one): New Application ____ Renewal ____

Part B: Applicant Information:

Drug Free Workplace Coordinator: _____

Company Name: _____

FEIN: _____

Corporate Address: _____

City: _____ State: _____ Zip: _____

County: _____

Phone: _____

E-Mail Address: _____

Number of Employees: _____ Type of Business: _____

Workers' Compensation Insurance Carrier: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Kentucky Location Physical Address: _____

City: _____ State: _____ Zip: _____

TO BE COMPLETED BY THE DEPT. OF WORKERS' CLAIMS

Date of First Certification: _____

or

Date of Re-Certification: _____

Approved By: _____

Certificate Sent By: _____ Date: _____

Part C: Checklist:

Page_____ A copy of a drug free workplace statement is given to each employee and posted in a prominent place at the place of employment;

Page_____ The copy notifies employees that the unlawful manufacture, distribution, dispensation, possession, or use of alcohol or a controlled or illicit substance is prohibited in the workplace;

Page_____ The copy specifies the actions that will be taken against employees for violations of such prohibition;

Page_____ An alcohol and substance abuse education and awareness training program for all employees and supervisory personnel has been established;

Page_____ A program has been established that includes alcohol and drug testing;

Page_____ An Employee Assistance Program is provided which includes professional assessment of employee personal concerns; confidential and timely identification services with regard to employee alcohol or substance abuse; referrals to employees for appropriate diagnosis, treatment and assistance with regard to employee alcohol or substance abuse; and follow-up services for employees who participate in a drug or alcohol rehabilitation program;

Page_____ A drug free workplace will be maintained throughout the workers' compensation insurance policy period;

Page_____ All of the above complies with the regulatory requirements of 803 KAR 25:280.

Part D: Copies of the following documents shall be attached to the initial application. The documents shall not be attached to renewal application unless a substantial change is made to the documents previously filed with the Dept. of Workers' Claims:

Page_____ Drug Free Workplace Policy

Page_____ A Statement identifying each alcohol and drug test that will be conducted

Page_____ A Statement identifying the company's Employee Assistance Program

Page_____ A description of the alcohol and substance abuse education and awareness training program for employee and supervisory personnel

Page_____ A Statement describing the confidentiality of the company's drug free workplace program

Page_____ Documents provided to employees

Part E: Employers Certification & Affidavit:

As a duly authorized agent of the license applicant named above, I hereby certify:

- (a) That the frequency and duration of each employee and supervisor training session meets the requirements of 803 KAR 25:280;
- (b) That all employees and supervisory personnel have participated or will participate during the calendar year in the required alcohol and substance abuse education and awareness training:
and
- (c) That the information I have provided in this Application/Affidavit is true and correct to the best of my knowledge.

Signature: _____

Name in Print: _____

Title: _____

STATE OF _____

COUNTY OF _____

Subscribed and sworn to before me by _____

This _____ day of _____, 20_____.

Notary Public _____

My Commission expires: _____