**BWC Substance Use Recovery and Workplace Safety Program**

*Request for Reimbursement*

|  |  |
| --- | --- |
| Company name |  |
| Point of contact |  |
| Address |  |
| Phone number |  |
| Email Address |  |
| BWC policy number |  |
|  |  |
| **Requested reimbursement amount**  |  |

**Reimbursement for manager/supervisor training**

|  |  |
| --- | --- |
| Training vendor |  |
| Trainer name & credential |  |
| Total cost of training |  |

|  |  |
| --- | --- |
| Training participant name | Job title |
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**Reimbursement for drug testing**

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| --- | --- |
| Provider |  |
| Total cost of drug testing |  |

|  |  |  |
| --- | --- | --- |
| Individual tested (Name or unique identifier) | Type (Pre-employment, Random, Reasonable suspicion) | Result (Pass/Fail) |
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**IMPORTANT: The following attachments must accompany this request (required).**

* W-9 Form
* Curriculum overview
* Invoice

Email completed form to participating ADAMH Board in your county, as follows.

* Montgomery: amack@mcadamhs.org
* Ross (Paint Valley): contactus@pvadamh.org
* Scioto: alsbd@adamhsals.org