BWC
Better Workers' Compensation
Built with *you* in mind.

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

INSTRUCTIONS:
- Please print or type.
- You may complete this form online at www.ohiobwc.com or return completed form to:

Attention: Risk Special Programs, L-22
Ohio Bureau of Workers' Compensation
30 W. Spring Street
Columbus, Ohio 43215-2256

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 December 31, for the program year beginning January 1. Incomplete applications will be rejected.

Employers that have, on an average, 25 or fewer employees will participate in Drug-Free EZ: Small Business Solutions.

Check Program Period applied for:	Check the DFWP Program Level for which you are requesting approval:
☐ July 1 – June 30 ☐ January 1 – December 31	☐ Level 1 ☐ Level 2

Is this application being submitted by a contractor or subcontractor in relationship to a State of Ohio construction contract? ☐ Yes ☐ No

Name of employer and DBA		BWC Policy number	
Address	City	State	ZIP code
Federal Tax ID number	FAX number	Telephone number	
Employer contact person for DFWP or DF-EZ		Telephone number	

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? ☐ Yes ☐ No

If so, on what date did your program begin?

I hereby certify that my organization is applying to implement a Drug-Free Workplace (DFWP) 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 or meet the specified requirements, I agree to repay to the Ohio Bureau of Workers' Compensation any DFWP or DF-EZ 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.

Name of designated employer representative	X Signature	Date signed

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