APPLICATION FOR RE-CERTIFICATION OF
DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

DIRECTIONS: After reading and understanding the rules and guidelines, please complete the following application and return only this application and a $25.00 check for the re-certification fee to the following address. Keep the documentation of your compliance in your files for review by your insurer or the Department of Industrial Relations, Workers' Compensation Division.

Alabama Department of Industrial Relations
Finance Division, Room 228
Attn: Central Cashier
649 Monroe Street
Montgomery, Alabama 36131

Drug-Free Workplace
Coordinator:_____

Company:_____

Address: _____

_____

_____

Phone number: _(___)_____

Number of Employees: _____

This is our company's (Please check one.) _____second year, _____ third year, _____fourth year of application for re-certification as a drug-free workplace.

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TO BE COMPLETED BY THE DEPARTMENT OF INDUSTRIAL RELATIONS, WORKERS' COMPENSATION DIVISION.

Date of Re-certification:_____

Approved By: _____

****

I, _____, in my capacity
(Name)
as _____ , attest that the
(Title)
Drug-Free Workplace Policy for _____
(Company Name)
has not changed since the last certification by the Department of Industrial Relations, Workers' Compensation Division, on _____.
(Date of Previous Certification)

OR

I, _____, in my capacity
(Name)
as _____ , attest that the
(Title)
Drug-Free Workplace Policy for _____
(Company Name)
has changed since the last certification by the Department of Industrial Relations, Workers' Compensation Division, on _____. A copy
(Date of Previous Certification)
of the new/revised policy is attached for review by the Workers' Compensation Division.

Notarization of Certified Drug-Free Workplace Program

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

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

Sworn to and subscribed before me this _____ day of _____ 20___

_____
Notary Public

My Commission Expires: _____