CERTIFICATION OF DRUG-FREE WORKPLACE PROGRAM

Name of Employer:_____ Insurance Policy Number:_____
Address:_____
Contact Person: _____ Phone Number: _____
Date 2.5% Credit Received: _____ Date Drug Testing Began: _____

Testing:

The following types of drug tests are conducted: (Check all that apply)

___ Pre-employment
___ Reasonable Suspicion
___ Follow-up to Employee Assistance Programs
___ Post-Accident
___ Random (50% of all employees yearly)
___ Other_____

Notice Given To Employees: (Check all that apply)

___ Each employee was given a copy of the company's Drug-Free Workplace Policy
___ Notice was given to job applicants prior to testing
___ Each employee was given general advance notice of commencement of drug-testing

Education:

___ Employee Assistance Programs
___ Education seminar for employees

Laboratory and MRO:

Name of Medical Review Officer: _____
Name of NIDA-certified laboratory: _____
Address of laboratory: _____

_____ _____ _____
Officer/Owner Name Officer/Owner Signature Date

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT DRUG-FREE WORKPLACE PROGRAM AND AGREES TO ABIDE BY THE ATTACHED RULES

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