



Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

Phone: 615-532-1321 FAX: 615-253-5265 Email: DFW.Program@tn.gov
<http://www.tn.gov/workforce/article/drug-free-workplace-program>

DRUG FREE WORKPLACE PROGRAM APPLICATION

1. This application must be complete, legible and signed or it will be RETURNED.
2. This application must be resubmitted anytime the employer changes insurance carriers.
3. This form must be submitted to the Bureau. Please include the completed original copy of this form plus one photocopy, a copy of PROOF OF COVERAGE and two pre-addressed, stamped envelopes:
 - a. One addressed to your Workers' Compensation Insurance Carrier and
 - b. One addressed to the employer named below.
4. THIS APPLICATION MUST BE RENEWED ANNUALLY.

Check One: New application Renewal application Changed Insurance Carrier

Company Name Town of Ashland City FEIN: 62-60002639

Mailing Address PO Bo x36 City Ashland City State & Zip TN 37015

Business Address 101 Court St City Ashland City State & Zip TN 37015

Phone # 615-792-4211 Fax # 615-792-3501 Email _____

Name of Substance Abuse Program Administrator Workforce Essentials

Nature of Business City Government Total # of FT & PT employees 72

Workers' Compensation Insurance Carrier Public Entity Partners

Lab Certification (circle one): SAMHSA CAP-FUDTAP Other _____

Name of Testing Laboratory Quest Diagnostics City Tucker State GA ZIP 30084

Name of Medical Review Officer (MRO) Randy Barnett (Philadelphia, PA 19154) Phone # 800-324-3784

Have all employees hired prior to the date of this application been provided at least one hour of substance abuse training? Yes No

Have all employees hired prior to the date of this application been informed of your company's drug free program policies? Yes No

Effective date of your program 3/15/12

Renewal applicants only:

Number of tests performed in past 12 months for each of the following:

Job Applicants: Total _____ Positive _____ Routine Fitness for Duty: Total _____ Positive _____

Post work accident: Total _____ Positive _____ EAP Follow-up: Total _____ Positive _____

Random (optional): Total _____ Positive _____ Reasonable Suspicion Total _____ Positive _____

Have all employees that have undergone substance abuse training acknowledged, in writing, their attendance at that training and the existence of your company's drug free program policies? Yes No

I hereby certify that all provisions and requirements of the Tennessee Drug-Free Workplace Program as established by T.C.A. have been met and implemented. (To be signed by all applicants)

Owner/Officer's Signature and title Steve Allen Printed name 3-9-2021 Date

Bureau of Workers' Compensation Representative Signature _____ Title _____ Accepted Date _____