



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

Instructions

- Please print or type.
- You may submit the completed form in one of three ways.
 - Online – **ohiobwc.com**
 - Fax – (614) 728-3205
 - Mail – Attention: Employer Programs
Ohio Bureau of Workers' Compensation
30 W. Spring St., 22nd Floor
Columbus, OH 43215-2256

Name of employer and DBA		Federal Tax ID number	BWC policy number
Address	City	State	ZIP code
E-mail address	FAX number ()	Telephone number ()	
Employer contact person for Drug-Free Workplace Program (DFWP) or Drug-Free EZ Program (DF-EZ)		Telephone number ()	

Note—
BWC must receive a fully completed application, signed by a designated employer representative. BWC will not accept incomplete applications.

Employers who have, on an average, 25 or fewer employees will participate in DF-EZ Program.

<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>*Level 0/comparable is comparable to Level 1, but is a category for state construction contractors only, and participants receive no discount from BWC.</p> </div>	<p style="text-align: right;">Check program period for which you are applying.</p> <p style="text-align: right;">July 1 – June 30 <input type="checkbox"/></p> <p style="text-align: right;">Jan. 1 – Dec. 31 <input type="checkbox"/></p> <p style="text-align: right;">Check the drug-free program level for which you are requesting approval.</p> <p style="text-align: right;">Level 0/Comparable program* <input type="checkbox"/></p> <p style="text-align: right;">Level 1 <input type="checkbox"/></p> <p style="text-align: right;">Level 2 <input type="checkbox"/></p>
---	--

Do you want BWC to place you on the State of Ohio construction contractor database, thereby making you eligible to bid/work on state jobs? Yes
No

Personnel Number of employees: _____
 [include all permanent full time, part time and intermittent/seasonal]

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

	X	
Name of designated employer representative	Signature	Date signed