

Virginia Drug-Free Certification Checklist

Please be advised that employers who establish a certified drug free workplace program are eligible for a premium credit of five percent (5%). This credit is provided as an incentive to prevent and reduce losses that are a result of alcohol and drug-related workplace accidents. The rules and procedures governing this program can be found in the FHM Insurance Company Agent's Underwriting Guidelines.

This form must be **completed and returned** to us with the appropriate documentation before premium credit can be established and processed. A program must be certified during each year you receive the credit. Failure to do so will remove you from eligibility for this credit.

Please check the items below that apply. A copy of applicable documentation as proof of compliance must be attached for each item below.

___ **A previously certified drug free workplace program** for which credit was received. *(Copy of applicable documentation, carrier name, and year of initial certification must accompany this form.)*

___ **A documented substance abuse policy or guidelines.** *(Copy of applicable policy or guidelines must accompany this form.)*

___ **Employee and supervisor education and training:** An education or training program regarding the established substance abuse policy and guidelines, the effects and dangers of substance abuse, and the available resources for counseling and treatment in the community.

___ **Periodic re-education and re-training:** A scheduled program to reinforce the Drug-Free Workplace Program.

___ **Employee Assistance Program (EAP):** Employees have access to an EAP or resource file of community prevention, intervention, and treatment programs through which employees can seek help on a voluntary, confidential basis.

___ **Drug Testing:** An established drug testing program. The following information must be provided:

Name of Certified Drug Testing Laboratory: _____

Point of Contact and phone for above: POC: _____ Phone: _____

Type(s) of testing conducted (Check ALL that apply):

___ Applicant (Pre-employment)

___ Post Accident

___ Follow Up (Rehabilitation)

___ Reasonable Suspicion

___ Random

___ Other: _____

I certify that the above information is accurate and that I may be subject to an additional premium charge if it is determined that there is any misrepresentation of the established drug free workplace program criteria.

Named Insured: _____

Named Insured's Representative: _____

Title: _____ **Policy Number:** _____

Signature: _____ **Date:** _____

EMPLOYERS' CERTIFICATION OF DRUG-FREE WORKPLACE

To provide for the safety and well being of our employees,

_____ will take the appropriate actions necessary to ensure a drug-free work environment. This may include pre-employment drug testing for all employees and for-cause testing of employees suspected of using drugs.

Signature: _____

Print Name: _____

Title: _____ Date: _____