

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

DIRECTIONS: After reading the Department's Administrative Rules and the Drug-Free Workplace Program Guide, please complete the following re-certification. Return this application, a \$25.00 check for re-the certification fee, and a copy of your Drug-Free Workplace Policy to the address below (if changed from previous on file.) Keep the documentation of your compliance in your files for review upon request by your insurer or the Department of Workforce, Workers' Compensation Division.

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

Drug-Free Workplace Coordinator: _____

Company: _____

Address: _____

Email Address: _____

Phone number: _____

Number of Employees: _____

This is our company's _____ year of application for re-certification as a drug-free workplace.

**TO BE COMPLETED BY THE DEPARTMENT OF WORKFORCE, 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 Workforce, 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 Workforce, Workers' Compensation Division, on
_____. A copy of the new/revised
(Date of Previous Certification)
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: _____