Ohio | Bureau of Workers' Compensation

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 listed below.

Online – **ohiobwc.com**
Fax – 614-621-1405
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 completed, signed application by June 30 for the program year that begins July 1 of the same year or by Dec. 31 for the program year that begins Jan. 1 of the following year. We will process fully completed, signed applications that are received electronically or post marked by the deadline date. We will not process incomplete applications. Employers who maintain 25 or fewer employees will participate in the DF-EZ. Group experience or group retrospective-rating plan participants are **NOT** eligible to receive the DFWP/DF-EZ discount.

*Level 0/comparable is comparable to Level 1, but is a category for state construction contractors only, and participants receive no discount from BWC.

Check program period for which you are applying.
July 1 – June 30 ☐
Jan. 1 – Dec. 31 ☐

Check the drug-free program level for which you are requesting approval.
Level 0/Comparable program* ☐
Level 1 ☐
Level 2 ☐

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

I hereby certify my organization is applying to implement a DFWP or DF-EZ pursuant to Rule 4123-17-58 or 4123-17-58.1 of the Ohio Administrative Code. I also certify my organization is willing to meet, at minimum, the requirements associated with the level of program for which I have applied. This includes timely submission of a fully completed annual report, which BWC must receive by the deadline date or be post marked by that date as specified by rule. When failing to fully implement the DFWP or DF-EZ, or meet the specified requirements, I agree to repay to the Ohio Bureau of Workers' Compensation any DFWP or DF-EZ 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.

Name of designated employer representative	X Signature	Date signed

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