

NOTICE TO EMPLOYER: IF YOU HAVE A DRUG-FREE WORKPLACE PROGRAM ESTABLISHED AND MAINTAINED IN ACCORDANCE WITH FLORIDA LAW AND YOU WOULD LIKE TO APPLY FOR THE 5% PREMIUM CREDIT THAT IS AVAILABLE, PLEASE COMPLETE THIS FORM AND FORWARD IT TO AMTRUST. RE-CERTIFICATION IS REQUIRED ANNUALLY.

**APPLICATION FOR
DRUG FREE WORKPLACE PREMIUM CREDIT PROGRAM**

Name of employer _____

Date of program implementation _____ Policy # _____

Testing:

Procedures for drug testing established and/or drug testing conducted in the following areas:

- | | |
|---|--|
| <input type="checkbox"/> Job Application | <input type="checkbox"/> Routine fitness for duty |
| <input type="checkbox"/> Reasonable Suspicion | <input type="checkbox"/> Follow-up to Employee Assistance Programs |

Notice of employer's drug testing policy:

- | | |
|---|---|
| <input type="checkbox"/> Copy to all employees prior to testing | <input type="checkbox"/> General notice given 60 days prior to testing |
| <input type="checkbox"/> Posted on all employer's premises | <input type="checkbox"/> Show notice of drug testing on vacancy announcements |
| <input type="checkbox"/> Copies available in personnel office or other suitable locations | <input type="checkbox"/> No notice required because the employer had a drug testing program in place prior to this rule's effective date (07/01/90) |
| <input type="checkbox"/> Copy to applicants prior to testing | |

Education:

- Resource file on providers
- Employee Assistance Programs
- Annual Education Course

Name of Medical Review Officer _____

A. Name of approved Department of Health & Rehabilitative Services lab.

B. Lab Phone # _____

C. Lab Address _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signed _____ Title _____ Date _____
(Application must be signed by an officer or owner)

Sworn and subscribed before me this _____ day of _____, _____.

Notary Public - State of Florida My Commission expires _____

Note: By granting a premium credit, AmTrust does not guarantee that any drug-free workplace program is sufficient to deny claims for injuries to employees who test positive for drugs. To qualify for claim denial, your program must strictly adhere to state law. AmTrust assumes no responsibility for the legality of any drug-free workplace program.