| Form HS-36-A | ARKANSAS WORKERS' COMPENSATION COMMISSION | HS-36-A |
|---|---|---|
| Ark. Code Ann. §11-14-101 & AWCC Rule 36<br>Rev. 7-1-2010 | **HEALTH & SAFETY DIVISION**<br>324 Spring Street, Little Rock, AR 72201<br>Mail: P. O. Box 950, Little Rock, AR 72203-0950<br>501-682-3930 / 1-800-622-4472 | |

## Application for Voluntary Drug-Free Workplace Program

Application Type: ❑Initial/first time application ❑Renewal (Approval no.________) ❑ Termination of Participation

| Company Information | | | |
|---|---|---|---|
| 1) Company name: | | 2) Address: | |
| 3) City: | | 4) State | 5) Zip: |
| 6) FEIN: | 7) NAICS: | 8) Effective date of drug-testing program: | |
| 9) Company contact: | | 10) Telephone no.: ( ) | |
| 11) Title: | | 12) e-Mail: | |
| 13) Workers' compensation insurance (WCI) status: ❑Self-insured ❑Purchase (WCI) | | | |
| 14) Insurance carrier or third party administrator (TPA): | | | |
| 15) Average number of employees during the most recent calendar year: | | 15a) Full-time: | 15b) Part-time: |
| | | | |
| | | | |

| Drug Testing Program | | | | |
|---|---|---|---|---|
| ***Program Manager or Third Party Administrator*** 16) Name: | | | | |
| 17) Address: | | | | |
| 18) City: | 19) State: | 20) Zip: | 21) Telephone no. | 22) E-Mail: |
| ***Testing Lab***: 23) Name: | | | | |
| 24) Address: | | | | |
| 25) City | 26) State: | 27) Zip: | 28) Telephone no.: ( ) | |
| | | | | |
| 29) Certification No. (enter lab certification no; only one is required) | SAMHSA: | CAP-FUDTAP: | Other: | |
| ***MRO:*** 30) Name: | | 31) Address: | | |
| 32) City: | 33) State: | 34) Zip: | 35) Telephone no.: ( ) | |
| 36) MRO certification no.: | 37) If not certified MRO, other qualifying certification (please attach explanation describing how this meets the Rule 36 requirements for an MRO): | | | |

**(38) Summary Statistics**

*Please attach the most recent year-end summary report from your testing laboratory or a letter certifying that no tests were required to be performed and why (no hires, no accidents, etc.).*

**Employer Certification** *(complete for all applications)*

I certify the above information is, to my best knowledge, true and accurate. I further certify that I understand submitting false information on this application may constitute workers' compensation fraud (Ark. Code Ann. §11-9-106). I certify that at each of the above mentioned locations a drug-free workplace program has been put in place which is in full compliance with the requirements of AWCC Rule 36.

(39)________________________________________ ____________________

Signature of Owner/Officer and Title Date

(40)________________________________________ ____________________

Notary/Date and State of Commission Date

The completed and notarized application should be sent to:

**Voluntary Drug-Free Workplace Program**
**Health and Safety Division**
**Arkansas Workers' Compensation Commission**
**P.O. Box 950**
**Little Rock, AR 72203-0950**

HS-36-A