



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

Form with fields: 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).

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.

Check program period for which you are applying. July 1 - June 30 [] Jan. 1 - Dec. 31 []
*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 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 Signature Date signed