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

Voluntary Drug-Free Workplace Program (VDFWP)

Annual Insurance Carrier Report

Carrier Information

1) Insurance Carrier:	2) Address:	3) City:
		4) State:
		5) Zip:
6) NAIC Carrier Identification No.:		7) NAIC Insurance Group No.:
8) Contact:	9) Telephone: ( )	10) e-Mail:

Client Information

Please complete the following information for each client awarded premium credits for the most recent calendar year for its Voluntary Drug-Free Workplace Program (VDFWP)

Client Name	Address	Did the insurance company audit the client's VDFWP		Briefly note any assistance provided to the client by the insurance company in either implementing or maintaining its VDFWP
		Yes	No	

I certify that the above information is correct to, the best of my knowledge, and I have read and understand the provisions of Ark. Code Ann. §11-14-101 & AWCC Rule 36.

_____ _____ _____

Designated Insurance Company Representative | Position or Title | Date