



STATE OF INDIANA DRUG-FREE / SMOKE-FREE WORK PLACE CERTIFICATION

Provider Partner will give written notice to the State within ten (10) days after receiving actual notice that the Provider Partner or an employee of the Provider Partner in the State of Indiana has been convicted of a criminal drug violation occurring in the workplace. False certification or violation of the certification may result in sanctions including, but not limited to, suspension of grant payments, termination of the Grant and/or debarment of grant opportunities with the State of Indiana for up to three (3) years. In addition to the provisions in this certification, if the total Grant amount set forth in this Grant Agreement is in excess of \$25,000.00, Provider Partner hereby further agrees that a Memorandum of Agreement is expressly subject to the terms, conditions and representations of the following certification:

Pursuant to Executive Order No. 90-5, April 12, 1990, issued by Governor Evan Bayh, the Indiana Department of Administration requires the inclusion of this certification in all contracts with and grants from the State of Indiana in excess of \$25,000. No award of a contract or grant shall be made, and no contract, purchase order or agreement, the total amount of which exceeds \$25,000, shall be valid unless and until this certification has been fully executed by the Agency of Provider Partner and attached to the Memorandum of Agreement as part of the contract documents. False certification or violation of the certification may result in sanctions including, but not limited to, suspension of contract payments, termination of the contract or agreement and/or debarment of contracting opportunities with the State for up to three (3) years.

The Provider Partner certifies and agrees that it will provide a drug-free/smoke free workplace by:

- (a) Publishing and providing to all of its employees a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Provider Partner workplace and specifying the actions that will be taken against employees for violations of such prohibition; and
- (b) Establishing a drug-free/smoke-free awareness program to inform its employees about (1) the dangers of drug abuse in the workplace; (2) the Provider Partner's policy of maintaining a drug-free/smoke free workplace; (3) any available drug counseling, rehabilitation, and employee assistance programs; and (4) the penalties that may be imposed upon an employee for drug abuse violations occurring in the workplace; and
- (c) Notifying all employees in the statement required by subparagraph (a) above that as a condition of continued employment the employee will (1) abide by the terms of the statement; and (2) notify the Agency and the State of Indiana of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction; and
- (d) Notifying in writing to Agency and the State ten (10) days after receiving notice from an employee under subdivision (c) (2) above, or otherwise receiving actual notice of such conviction; and
- (e) Within thirty (30) days after receiving notice under subdivision (c) (2) above of a conviction, imposing the following sanctions or remedial measures on any employee who is convicted of drug abuse violations occurring in the workplace: (1) take appropriate personnel action against the employee, up to and including termination; or (2) require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
- (f) Making a good faith effort to maintain a drug-free/smoke free workplace through the implementation of subparagraphs (a) through (e) above.

THE UNDERSIGNED AFFIRMS, UNDER PENALTIES OF PERJURY, THAT HE OR SHE IS AUTHORIZED TO EXECUTE THIS CERTIFICATION ON BEHALF OF THE DESIGNATED ORGANIZATION.

Printed Provider Partner Name

Signature of Authorized Representative
Of Provider

Date

Printed Name of Signing Representative

Title