Department of Workforce Development
Unemployment Insurance Division
P.O. Box 7905
Madison, WI 53707

Fax: (608) 260-2506
Email: UIDrugTest@dwd.wi.gov

Completion of Substance Abuse Treatment

Please return completed form by mail, fax or encrypted email within 7 days of the date of completion of treatment. Failure to return the form could result in denial of benefits to the claimant and no payment for services will be processed.

Individual Information

First Name	Middle Initial	Last Name		
Address	City		State	Zip Code
Social Security Number	ID Number			

Treatment Facility Information

Treatment Facility Name			
Address	City	State	Zip Code
Contact Name	Title	Phone Number	

Treatment Facility Certification

☐ I certify that the above individual has successfully completed the substance abuse treatment plan created by this facility.

☐ The plan was completed on: _____/_____/_____

Name of Treatment Facility Employee Certifying Completion	Title
Phone Number	Date / /