CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Em	ployer Name:			
Name of Contact Person:		Te	Telephone #:	
Policy #:		Effective Date of Policy:		
Stati	submitting a copy of my workplace safety progutes. I certify that this safety program has been y carrier.			
	is to certify that my workplace safety program 1025, Florida Statutes:	meets or exceeds the foll	lowing provisions as provided for in Section	
1) 2) 3) 4)	Written safety policy and safety rules Safety inspections Preventive maintenance Safety training	,	First aid Accident investigation Necessary record keeping	
	aware that I may be subject to an on-site inspension is information.	ection by my carrier, for the	he purpose of validating the accuracy	
appl amo	person who knowingly, and with intent to injure ication containing any false, incomplete, or mis unt of premiums for workers compensation covection 775.082, s. 775.083, or s. 775.084, Florid	leading information with terage is guilty of a felony	the purpose of avoiding or reducing the	
	er penalties of perjury, I declare that I have rea nium Credit, and that the facts stated in it are tr		ion of Employer Workplace Safety Program	
	Employer Name	Date	Officer/Owner Signature*	
			Title	
`Арр	olication must be signed by an officer or owner.			

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