Contractor’s Name:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Year | Incident Rate | Lost Work Day Index | Cost of Accident per Employee | Experience Modification Rating | No. of Fatalities | No. of Lost Work Days | No. of Recordable Injuries |
| 2009 |  |  |  |  |  |  |  |
| 2008 |  |  |  |  |  |  |  |
| 2007 |  |  |  |  |  |  |  |

Incident Rate = (Number of Injuries and Illnesses) x 200,000

Total Hours Worked

Lost Work Day Index = (Number of Lost Work Days) x 200,000

Total Hours Worked

Cost of Accident per Employee = Total Cost of Accidents

Average Number of Employees

Experience Modification Rating = Actual Claims per Year

Expected Claims Based on Past 3 Year Trending

Under penalty of perjury, I certify that I am the company’s Official Representative and that, to the best of my knowledge and belief, following reasonable inquiry; the foregoing is true and correct.

By: Print Name:

Title: Date:

*[Please make additional copies of this form and attach additional sheets as needed.]*