

**Direct Dial: (717) 783-4467**

**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF LABOR & INDUSTRY  
OFFICE OF CHIEF COUNSEL  
BUREAU OF WORKERS' COMPENSATION  
June 25, 1999**

**PRIVILEGED AND CONFIDENTIAL ATTORNEY WORK PRODUCT**

**TO:** Mary Lou Harris  
Senior Regulatory Analyst

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**FROM:** Thomas J. Kuzma *TJK*  
Deputy Chief Counsel

**SUBJECT:** IRRC Regulation #12-54  
Department of Labor & Industry  
Proposed Health & Safety Regulations

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Enclosed please find the Regulatory Analysis Form (complete with all referenced forms) that you requested earlier today.

Please don't hesitate to call with any questions.

TJK/cae

Attachment

cc: Len Negley, Chief, Health & Safety Division

<h1 style="margin: 0;">Regulatory Analysis Form</h1>		<p><b>This space for use by IRRC</b></p>
<p><b>(1) Agency</b></p> <p style="text-align: center;">Department of Labor and Industry Bureau of Workers' Compensation</p>		<p><b>IRRC Number:</b></p>
<p><b>(2) I.D. Number (Governor's Office Use)</b></p>		
<p><b>(3) Short Title</b></p> <p style="text-align: center;">Workers' Compensation Health and Safety</p>		
<p><b>(4) PA Code Cite</b></p> <p>34 Pa. Code Chapters 123, 125 &amp; 129</p>	<p><b>(5) Agency Contacts &amp; Telephone Numbers</b></p> <p><b>Primary Contact:</b> Len E. Negley 772-1917</p> <p><b>Secondary Contact:</b> Thomas Kuzma 783-4467</p>	
<p><b>(6) Type of Rulemaking (Check One)</b></p> <p><input checked="" type="checkbox"/> <b>Proposed Rulemaking</b></p> <p><input type="checkbox"/> <b>Final Order Adopting Regulation</b></p> <p><input type="checkbox"/> <b>Final Order, Proposed Rulemaking Omitted</b></p>	<p><b>(7) Is a 120 Day Emergency Certification Attached?</b></p> <p><input checked="" type="checkbox"/> <b>No</b></p> <p><input type="checkbox"/> <b>Yes: By the Attorney General</b></p> <p><input type="checkbox"/> <b>Yes: By the Governor</b></p>	
<p><b>(8) Briefly explain the regulation in clear and nontechnical language.</b></p> <p>The regulations will provide detailed guidelines for the administration and enforcement of the health and safety provisions of the Workers' Compensation Act (act) (77 P.S. §§1- et seq.). Those provisions were added to the act by the act of July 2, 1993 (P.L. 190, No. 44) (Act 44) and by the act of June 24, 1996 (P.L. 350, No. 57) (Act 57). The regulations will (1) explain the requirements for the accident and illness prevention programs which all individual self-insured employers and group self-insurance funds must maintain, (2) explain the requirement for the accident and illness prevention services which all workers' compensation insurers must maintain or provide to their policyholders, (3) explain the reporting requirements relating to such accident and illness prevention programs and services and (4) specify the qualification standards for personnel providing accident and illness prevention services for a workers' compensation insurance carrier, individual self-insured employer or group self-insurance fund. Those four areas of regulations relate to the provisions of section 1001 of the act. The regulations also will provide guidelines for the process by which an employer may gain certification and recertification of its workplace safety committee or committees under section 1002 of the act and amend certain provisions pertaining to vocational evaluations.</p>		
<p><b>(9) State the statutory authority for the regulation and any relevant state or federal court decisions.</b></p> <p>These regulations are proposed under the authority provided in section 435 of the act (77 P.S. §991), which provides that the Department of Labor and Industry (Department) will adopt regulations as necessary to explain and enforce the provisions of the act. In addition to section 435 of the act, subchapter E of the regulations is proposed under section 1001 of the act (77 P.S. §1038.1). Section 1001 of the act requires the Department to issue regulations setting forth the qualification standards for accident and illness prevention personnel providing services under the act. Subchapter F is also proposed under the authority of section 1002 of the act (77 P.S. §1038.1). Section 1002 of the act requires the Department to set criteria for the certification and recertification of workplace safety committees established by employers.</p>		

# Regulatory Analysis Form

- (10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.**

The regulations under subchapter E are mandated by section 1001 of the act. That section requires the Department to issue regulations setting forth qualification standards for accident and illness prevention personnel providing services under the act.

- (11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?**

The regulations will implement the health and safety provisions of the act, which are intended to reduce the frequency and severity of injuries occurring in and illnesses resulting from the workplace. This will not only have a positive effect on the health and welfare of workers, but will also benefit employers by resulting in a healthier and more stable workforce and by reducing employers' costs for replacement workers and for workers' compensation.

- (12) State the public health, safety, environmental or general welfare risks associated with non-regulation.**

The major consequence of not promulgating regulations is that there would be no standards for the accident and illness prevention programs and services of insurers and self-insured employers and no mechanisms to measure the adequacy of such programs.

- (13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)**

Those who would most benefit from these regulations are workers, since the regulations implement provisions of the act designed to reduce injuries and illnesses in the workplace. Insured employers would also benefit since the regulations prescribe specific health and safety services which their insurers must make available to them. This is especially true for small employers, who may not have safety services available to them from other sources. Insurers, self-insured employers and group self-insurance funds should also benefit from the regulations. By reducing work-related injury and illnesses, the proposed regulations should reduce their costs for workers' compensation benefits and the administrative and legal expenses associated with the payment of such benefits.

- (14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)**

Generally, regulated parties should not be adversely affected by these proposed regulations. The proposed regulations define the administrative processes which allow affected parties to comply with the health and safety provisions of Acts 44 and 57. Most parties already operate programs and provide services in compliance with Acts 44 and 57 which meet these proposed regulations. There may be some individuals who do not meet the established service provider or training qualification levels. We have tried to mitigate this impact through modification of these requirements in response to comments and input received.

# Regulatory Analysis Form

- (15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)**

Subchapter B would regulate the health and safety activities of workers' compensation insurance carriers. Approximately 589 carriers wrote workers' compensation insurance in the Commonwealth in 1998. Subchapter C applies to individual self-insured employers, of which there are approximately 1,050 and Subchapter D applies to the 20 group self-insurance funds. Subchapter E will set qualification standards for the accident and illness prevention personnel employed or retained through contract by insurers, individual self-insured employers and group self-insurance funds. Additionally, subchapter F would affect all employers which apply for certification of their workplace safety committee.

- (16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.**

After the enactment of Act 44, the Department published a notice in the Pennsylvania Bulletin at 23 Pa. B. 4185 (August 28, 1993) which, among other things, provided guidance to all parties regarding the implementation of the health and safety provisions of Act 44. Interested parties were advised to write to the Department with information requests and requirements.

After the publication of the August 28, 1993 notice, the Department received various written comments and telephone inquiries and participated in numerous meetings with affected parties to provide guidance and to receive feedback on Act 44 health and safety implementation efforts. In addition, the Department employed a nationally known consultant in the field of occupational safety and health in order to assist in the development of the administrative requirements relating to health and safety provisions of the act.

The Department substantially expanded on the August 28, 1993 notice with the publication of a statement of policy at 25 Pa. B. 3943 (September 16, 1995). That statement of policy incorporated suggestions and comments of interested parties in giving further guidance to insurance carriers, self-insured employers, group self-insurance funds and employers regarding the Department's interpretation of sections 1001 and 1002 of the act, pending the promulgation of final regulations. The statement of policy further encouraged interested parties to contact the Department with suggestions and comments regarding the implementation of the health and safety provisions of the act. The regulations being proposed, which will supersede the statement of policy, include substantial provisions of the statement of policy. A number of comments and suggestions by interested parties were received on the statement of policy. Those comments and suggestions have been reviewed, and, if appropriate, they have been incorporated into the proposed regulations.

In April of 1996, the Bureau issued draft copies of annual report forms to all insurers, individual self-insured employers and group self-insurance funds. Those reports requested the type of information that insurers and self-insurers would have to provide under the proposed regulations if they were final. The insurers and self-insurers were asked to complete the forms on a voluntary basis and to return them to the Bureau with any comments or suggestions they might have on the forms. The Bureau received 43 reports from insurers, 134 reports from individual self-insured employers and 10 reports from group self-insurance funds, many with comments on how to improve the reports or to improve the information being sought. The Bureau has considered the comments and suggestions provided in response to the test release of the annual report and has modified the proposed regulations to incorporate those comments and suggestions as appropriate. Commencing in 1997, official report filings were required for insurers for the 1996 calendar year and for self-insured employers and group self-insurance funds according to application renewal periods. Assistance has been continually provided to aid parties in completing reports, understanding requirements and establishing program elements.

## Regulatory Analysis Form

- (17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.**

The regulated community under section 1001 of the act is comprised of insurers, individual self-insured employers and group self-insurance funds. These proposed regulations communicate reporting procedures and time requirements for which costs have already been incurred in accordance with the workers' compensation law. There may be some additional, minor administrative costs associated with these proposed regulations, but these should not add significantly to costs already absorbed.

The regulated community for section 1002 of the act is comprised of employers which request certification of the safety committees operating at their workplaces. Section 1002(b) grants a 5% one-time reduction in workers' compensation premiums to those insured employers which receive Department certification for the workplace health and safety committees. Act 57 extended receipt of the 5% discount from one year to a possible total five years. As of February 1999, the safety committee certification program had saved employers approximately \$51.5 million through reduced insurance premiums since the program's implementation in March 1994. The premium savings is an incentive to introduce employers to the long-term benefits of safety committees. Successful safety committees and overall safety programs can reduce injuries and illnesses, resulting in additional reductions to workers' compensation costs.

Costs associated with the establishment and operation of safety committees are not available, but general comments report them to be minimal.

- (18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.**

Local governments, as well as other public sector employers, will be affected by the regulations to the same extent as private sector employers.

- (19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.**

Administering the health and safety oversight provisions has required the Commonwealth to incur expenditures for personnel, office space, furniture, equipment and data processing support. The Department operating costs of the health and safety program in FY 1997-98 were estimated to be \$521,000, including \$427,000 for personnel costs, \$64,000 for operating costs and \$30,000 in fixed assets. The regulations would not require the Department to increase significantly its operating costs for their oversight. The Department's costs for the administration of the health and safety program, as well as all costs associated with the administration of the act, is funded through assessments into the Workmen's Compensation Administration Fund.

The Commonwealth also incurs cost for health and safety programs for its employees as a self-insured employer. Such costs are included with those of the entire regulated community under the discussion for number 17.

# Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY+1 Year	FY+2 Year	FY+3 Year	FY+4 Year	FY+5 Year
<b>SAVINGS:</b>						
<b>Regulated Community</b>						
<b>Section 1001</b>						
<b>Section 1002</b>	\$ 8,429,000	\$ 9,271,000	\$10,199,000	\$11,219,000	\$12,341,000	\$12,000,000
<b>Total Savings</b>	\$8,429,000	\$ 9,271,000	\$10,199,000	\$11,219,000	\$12,341,000	\$12,000,000
<b>COSTS:</b>						
<b>Regulated Community</b>						
<b>Local Government</b>						
<b>State Government</b>						
<b>Total Costs</b>						
<b>REVENUE LOSSES:</b>						
<b>Regulated Community</b>						
<b>Local Government</b>						
<b>State Government</b>						
<b>Total Revenue Losses</b>						

(20a) Explain how the cost estimates listed above were derived.

Savings to insurers, individual self-insured employers and group self-insurance funds resulting from section 1001 are not estimated. Overall savings should result from reductions in workplace injuries and illnesses brought about by implementation of prevention programs and services, but there is no basis for estimating dollar figures. An estimated annual increase in insurance premium savings from safety committees of 10% is used through the current year plus four in the above chart. The savings should level off or reduce in the current year plus five as the five year discount expires for employers certified in the current year.

# Regulatory Analysis Form

**(20b) Provide the past three year expenditure history for programs affected by the regulation.**

Program	FY-3	FY-2	FY-1	Current FY (1997-1998)
Health & Safety Division	\$100,000.00	\$300,000.00	\$444,000.00	\$521,000.00

**(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.**

While the costs of the regulations have not been projected, the savings which would result if the health and safety provisions reduce workers' compensation losses should far exceed the likely costs.

**(22) Describe the non regulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.**

No effective non-regulatory alternative to the regulations could be identified. The regulations explain provisions of the act. The non-promulgation of regulations would leave insurers, self-insured employers and group self-insurance funds without clear direction on required elements of their safety services or programs. The lack of regulations would hamper the Department's ability to enforce the provisions of the act. While a statement of policy was issued as an interim measure, a statement of policy or internal guidelines in lieu of regulations would not be effective since they lack the force of law.

**(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.**

A major alternative regulatory scheme was considered for subchapter E relating to service provider qualification standards. The Department had considered the development of a test for use in proving qualifications as an accident and illness prevention professional. That scheme, which would have added some cost to the operation of the Department, was rejected. The Department concluded that testing would have placed an administrative burden on individuals without providing an effective measurement of competency and knowledge in the field in return.

# Regulatory Analysis Form

- (24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.**

There are no federal standards regulating the activities of workers' compensation insurers in health and safety. While the Occupational Safety and Health Administration (OSHA) does set workplace safety standards for private sector employers, which includes certain employers which are self-insured in Pennsylvania, those standards are substantially more detailed and stringent than the subject regulations.

- (25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?**

The requirements of the act relating to health and safety are limited when compared in general to other states. For instance, workers' compensation statutes in Oregon, California, Texas and other states place requirements on all employers with more than a certain number of employees. The proposed regulations, which are in response to the act, are modest and appropriate, based on the comments provided by the regulated community regarding the policy statement which preceded the proposed regulations. They will not negatively affect Pennsylvania's competitiveness with other states.

- (26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.**

The proposed regulation would supersede the statement of policy published at 25 Pa. B. 3943 (September 16, 1995). The proposed regulation would not affect other regulations of the Department or the regulations of other state agencies.

- (27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.**

After the proposed regulations are published, the Bureau will honor any requests to meet about them with parties interested in or affected by them. The number of such requests which will be received and the details of such meetings are unknown at this time.

# Regulatory Analysis Form

- (28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available.**

The act requires insurers, self-insured employers, and group self-insurance funds to file annual reports of their accident and illness prevention programs and services including service provider qualifications to the Department. The forms which will be used for that purpose are attached. Some additional forms must be completed by an insurer, self-insured employer or group self-insurance fund prior to it undergoing an audit of its program by the Bureau. The procedures for such audits are outlined in the proposed regulations. Further attached are the forms relating to the certification and recertification of safety committees under the act.

- (29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.**

None

- (30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?**

The proposed regulations will be effective upon their final publication in the Pennsylvania Bulletin.

- (31) Provide the schedule for continual review of the regulation.**

A sunset date will not be necessary for these proposed regulations. The regulations will be continuously monitored by the Workers' Compensation Advisory Council and by the Department in the day-to-day administration of the act and the regulations. If needed, corrections can be initiated based on the information obtained from those operations. The Department will also convene a meeting of insurers, self-insured employers and group self-insurance funds on an annual basis after the publication of final-form regulations to receive information and feedback on the operation of the regulations.



## COMMONWEALTH OF PENNSYLVANIA

**INSURER'S INITIAL REPORT OF ACCIDENT & ILLNESS  
PREVENTION SERVICES**

*This Report Must be Submitted with the Application for Licensure to write Worker' Compensation Insurance in the Commonwealth of Pennsylvania*

*(Please type or print all information. Refer to Instructions before completing this form)*

FEIN

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Federal Employer's Identification Number

NAIC

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National Association of Insurance  
Commissioners Code

1. Insurer Name:

2. Mailing Address:

3. Is the Insurer prepared to notify Policyholders of the Availability of Accident &amp; Illness Prevention Services?

( ) YES [ If "YES" attach Sample Copy of the Policyholder Notification. Label as ITEM #3]

( ) NO [ If "NO" indicate when Policyholder Notice will be Available]

When Available: \_\_\_\_\_

4. Which of the following Method(s) will be utilized in determining Policyholder Accident &amp; Illness Prevention Service Commitments? ( Check all that apply)

( ) a. Policyholder Request

( ) g. Broker Request

( ) b. Loss History

( ) h. Standard Industrial Classification (SIC) Code

( ) c. Loss Ration

( ) i. Experience Modification Factor

( ) d. Incurred Losses

( ) j. Others [ Explain - Identify as ITEM # 4 (j) on additional sheet]

( ) e. Paid Losses

( ) f. Underwriter Request

5. Will Policyholder On-Site Hazard Identification Surveys be conducted for the purpose of determining Accident & Illness Prevention Service needs?

( ) YES      ( ) NO      [ If "NO" attach an Explanation of how Policyholder Accident & Illness Prevention Service needs will be determined. label as ITEM #5]

6. Indicate Under Column I, the type(s) of Accident & Illness Prevention services that you are in a position to **Maintain** or **Provide** for Policyholders. Indicate Under Column II and/or Column III whether Insurer Qualified Staff Service providers, or Contracted Qualified service Providers will provide each of the Services listed Under Column I.

<u>SERVICES</u>	<u>COLUMN I</u>	<u>COLUMN II</u> <u>Staff</u> <u>Provider</u>	<u>COLUMN III</u> <u>Contracted</u> <u>Provider</u>
a. On-Site Surveys/Recommendations	_____	_____	_____
b. Analysis of Accident Causes	_____	_____	_____
c. Accident & Illness Prevention Evaluation	_____	_____	_____
d. Industrial Hygiene Services	_____	_____	_____
e. Industrial Health Services	_____	_____	_____
f. Accident & Illness Prevention Training	_____	_____	_____
g. Consultations	_____	_____	_____
h. Pre-Operational Process Reviews	_____	_____	_____
i. Safety Committee Training	_____	_____	_____

7. Indicate the type(s) of accident & Illness Prevention Materials that are to be made available to Policyholders.

- |                                       |  |
|---------------------------------------|--|
| ( ) a. Audio Visual Material          | ( ) e. Sample Programs   |
| ( ) b. Poster/Payroll Stuffers        | ( ) f. Awards  |
| ( ) c. Booklets, Brochures, Pamphlets | ( ) g. Other [Explain - Identify as ITEM #7 (g) on additional sheet] |
| ( ) d. Regulations/Standards          |  |

8. Which of the following Method(s) will be used to determine the Effectiveness of Accident & Illness Prevention services?

- |   |   |
|---|---|
| <input type="checkbox"/> a. Incidence Rate Comparison | <input type="checkbox"/> e. Loss Ration Comparison  |
| <input type="checkbox"/> b. Recommendations Closed    | <input type="checkbox"/> f. Experience Modification Factor                                |
| <input type="checkbox"/> c. Incurred Losses           | <input type="checkbox"/> g. Other [Explain - Identify as ITEM #8 (g) on additional sheet] |
| <input type="checkbox"/> d. Satisfaction Surveys      |   |

I the undersign, verify that the facts set forth in this report and any attachments are true and correct. This verification is made subject to the penalties of section 4909 of the Crime Code, 18 PA C. S. Subsection 4909 relating to unsworn falsification to authorities.

_____	_____	(_____)_____
Point of Contact (Please Print)	Title	Telephone Number
_____	_____	
Signature	Date Signed	

(Please Attach Additional Sheets, Where Necessary, Labeled with the Appropriate Form Section Number and Letter)

**Send this completed report along other Application Material to:**

Pennsylvania Insurance Department  
Bureau of Licesening and Financial Analysis  
1345 Strawberry Square  
Harrisburg, PA 17120  
(717) 787-2735

# Instructions for Completing Form LIBC-211I

## INSURER'S INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

- ITEM 6:** Mark with an (✱) under Column I, the types of Accident & Illness Prevention Services that you are in a position to **Maintain** or **Provided** for Policyholders. (the Accident & Illness Prevention Services listed under the "SERVICE" heading are the minimal that an Insurer must be in a position to maintain or provide for Policyholder as a prerequisite for a license to write Workers' Compensation Insurance within this Commonwealth). Indicate in Column II and/or Column III, whether insurers in-house qualified employee services providers, or qualified contracted services providers, will provide these services.
- ITEM 7:** Mark with an (✱) the type(s) of Accident & Illness Prevention material(s) that will be provided to policyholders.
- ITEM 8:** Mark with an (✱) the internal method(s) to be utilized in determining the effectiveness of Accident & Illness Prevention Service(s). Methods could include, but are not limited to: (a) comparisons of incidence rates as calculated by the policyholder or insurer; (b) submitted recommendations that are considered closed; (c) comparisons of the number of incurred or paid losses for a specific period; (d) results of customer satisfaction surveys; (e) comparisons of loss ratios for a specific period; (f) experience modification factor; (g) other method, please explain using an attached sheet identified as ITEM # 8(g).

# Instructions for Completing Form LIBC-2111

## INSURER'S INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

This form must be filed with the Pennsylvania Insurance Department when submitting the application for licensure to write workers' compensation insurance in the Commonwealth of Pennsylvania.

**NOTE:** The term *Accident & Illness Prevention Services* as described in the Pennsylvania Workers Compensation Act is synonymous with the terms *Safety and Health Program* and *Loss Control Program*.

**FEIN (Federal Employer Identification Number), NAIC (National Association of Insurance Commissioners Code)**

Enter the Federal Employers Identification Number assigned to you and the National Association of Insurance Commissioners number assigned to you.

- ITEM 1:** Provide the full name of the insurance carrier. A separate report is required of each company applying for a license for Workers' Compensation authority from the Pennsylvania Department of Insurance.
- ITEM 2:** Provide the complete mailing address of the Insurance Carrier.
- ITEM 3:** Mark with an (X) "Yes" or "No" regarding Policyholder Notification of Accident & Illness Prevention Services. If the Insurer has a prepared Policyholder Notice of the availability of Accident & Illness Prevention services "YES" should be checked. Identify the Notice as ITEM #3, and attach a copy of the Notice to the report. (*The Pennsylvania Workers' Compensation Act* [Section 1001(d)] requires that; "insurers notify policyholders of the availability of Accident & Illness Prevention Services; that this notification be in at least **10 point bold print**; and that the notification accompany each workers' compensation insurance policy delivered or issued for delivery in the Commonwealth. If "NO" is checked you must indicate when the Notice will be available. It is suggested that a copy of the Policyholder Notification be forwarded to the Health and safety Division for review prior to issue.
- ITEM 4:** Mark with an (X) the method(s) to be utilized for determining Policyholder Accident & Illness Prevention Service(s) commitments. Method(s) could include, but not be limited to: (a) policyholder request; (b) loss history; (c) loss ratio (incurred losses ÷ earned premium); (d) incurred losses; (e) paid losses; (f) request by underwriters as a component of coverage; (g) policyholder request; (h) request by brokers as an account agreement; (i) insurer schedule by policyholder SIC Code; (j) experience modification factor: a factor developed by the **Pennsylvania Compensation Rating Bureau** that apportions the cost of workers' compensation insurance based upon losses reported, a modifier of < 1 usually indicates favorable loss experience; or (k) other method, please use an attached sheet identified as ITEM # 4(k).
- ITEM 5:** Respond "YES" or "NO" regarding the use of on-site hazard identification surveys as the means to determine Policyholders Accident & Illness Prevention Service(s) needs. If "NO", is checked you must attach an explanation as to how you will determine policyholder Accident & Illness Prevention Service(s) needs.

## INSURER'S ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

**See Attached Instructions for Completion of Report**

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$$\begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

Signature

**For Bureau  
Use Only**

**3 Total Written Direct Premiums**  
(Round to nearest dollar )

--	--	--	--	--	--	--

[illegible]

4c \$100,000 or more

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--	--	--	--	--	--

[illegible]☐ Yes

--	--	--	--	--	--	--

**If #8 is Less than # 7, Please  
Attach Explanation**

☐ Yes

☐ Other [Explain - Identify as Item 10j on additional sheets]

- 11 Mark with an (x) under Column I, the type(s) of Accident & Illness Prevention Services that are maintained or provided for policyholders. Mark with an (x) under Columns II and/or III to indicate whether Insurer's In-house Qualified Employee Service Providers or Qualified Contracted Service Providers provided these services. Indicate under Column IV the number of each service provided during period covered by this report.

	COLUMN I Service	COLUMN II Employee Providers	COLUMN III Contracted Providers	COLUMN IV Number of Each Service Provided
a On-Site Surveys/Recommendations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
b Analysis of Accident Causes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
c Accident & Illness Prevention Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
d Industrial Hygiene Surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
e Industrial Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
f Accident & Illness Prevention Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
g Consultations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
h Pre-Operational Process Reviews	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
i Safety Committee Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

- 12 Number of Qualified Accident & Illness Prevention Service Providers that Provided and/or were Available to Provide Program Services
- |                        |                          |
|------------------------|--------------------------|
| a Employee Provider(s) | b Contracted Provider(s) |
| <input type="text"/>   | <input type="text"/>     |

- 13 Indicate the Type(s) of Accident & Illness Prevention Informational and Promotional Materials You Provide to Policyholders

Mark with an (x) the Type(s) of Materials Provided

- |   |   |
|---|---|
| <input type="checkbox"/> a Audio-visual Material          | <input type="checkbox"/> e Sample Forms   |
| <input type="checkbox"/> b Posters/Payroll Stuffers       | <input type="checkbox"/> f Sample Programs  |
| <input type="checkbox"/> c Booklets, Brochures, Pamphlets | <input type="checkbox"/> g Awards   |
| <input type="checkbox"/> d Regulations/Standards          | <input type="checkbox"/> h Other [Explain - Identify as Item #13h on additional sheets] |

☐ a. Incidence Rate

☐ b. Recommendations Closed

☐ c. Incurred Losses

☐ d. Satisfaction Surveys

☐ e. Loss Ratio

☐ f. Experience Mod

☐ g. Other [Explain - Identify as Item # 14 g on additional sheets]

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## INDIVIDUAL SERVICE PROVIDER INFORMATION

**First Name**

[illegible][illegible][illegible]

--	--

Month      Day      Year

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 - 

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[illegible][illegible][illegible]☐ New Request for In-service

5

## INDIVIDUAL SERVICE PROVIDER INFORMATION

**First Name**

[illegible][illegible][illegible]

--	--

Month      Day      Year

-  -

### First Primary Service

[illegible][illegible][illegible]☐ New Request for In-service

6

### PROVIDER IDENTIFICATION NUMBERS

[illegible]

—

### PROVIDER IDENTIFICATION NUMBERS

8.	<div>Provider Number</div>	<div>Hiring Status</div>	<div>First Name</div>	<div>Middle Initial</div>
	<div>Last Name</div>			
9.	<div>Provider Number</div>	<div>Hiring Status</div>	<div>First Name</div>	<div>Middle Initial</div>
	<div>Last Name</div>			
10.	<div>Provider Number</div>	<div>Hiring Status</div>	<div>First Name</div>	<div>Middle Initial</div>
	<div>Last Name</div>			
11.	<div>Provider Number</div>	<div>Hiring Status</div>	<div>First Name</div>	<div>Middle Initial</div>
	<div>Last Name</div>			
12.	<div>Provider Number</div>	<div>Hiring Status</div>	<div>First Name</div>	<div>Middle Initial</div>
	<div>Last Name</div>			

**Send the Completed Insurer's Annual Report of Accident & Illness Prevention Services (LIBC-210I) to:**

8

# Instructions for Completing Form LIBC-210I

## INSURER'S ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

This Insurer's Annual Report of Accident & Illness Prevention Services must be filed with the Pennsylvania Department of Labor and Industry, Bureau of Workers' Compensation, Health and Safety Division for the preceding calendar year by March 1 of the following year for each Carrier which has been granted a license to write workers' compensation insurance within the Commonwealth of Pennsylvania. A calendar year is considered as that period from January 1 through December 31 of the Report year. If a Direct Writer, check the appropriate box and complete Items 1a thru 17. If Licensed, But Have Not Written Workers' Compensation, a Reinsurer or Excess Coverage Carrier only, check the appropriate box, fill in First Name, Middle Initial and Last Name, Title, Telephone Number, Date, and sign at the bottom of the first page and return to the address on page 8.

**FEIN (Federal Employer Identification Number), BC/ICC (Bureau Code/Insurance Carrier Code), NAIC (National Association of Insurance Commissioners Code)**

Enter the Federal Employer's Identification Number (FEIN) assigned to you and the four digit Bureau Code/Insurance Carriers Code (BC/ICC) assigned to you by the Bureau of Workers' Compensation and the National Association of Insurance Commissioners Code (NAIC) number assigned to you.

- ITEM 1a:** The full name and address of the insurance carrier as registered with the Commonwealth of Pennsylvania is pre-printed for report tracking purposes.
- ITEM 1b:** Provide any corrections to the mailing address as it appears in 1a. in the spaces provided.
- ITEM 1c:** Check the appropriate box corresponding with the Insurer's status. (Direct Writer, Licensed, But have Not Written Workers' Compensation, or Reinsurer or Excess Carrier)
- NOTE:** *You are required to attach an explanation informing the Department as to the status of policyholder Accident & Illness Prevention Services, if your Insurer Status on your previous Annual Report was reported as "Direct Writer" and your current reporting status is other than "Direct Writer".*
- ITEM 2:** Indicate the total number of workers' compensation policyholders for whom coverage was provided within the Commonwealth of Pennsylvania, during the period covered by this report.
- ITEM 3:** State the net written premiums on direct business as reported on *Special Schedule W*, Parts A-1 thru A-5, Item #1, as filed with the Pennsylvania Insurance Department, rounded to the nearest dollar.
- ITEM 4:** Indicate the number of policyholders within each premium size category that received services during the period covered by this report. If no services were provided for a premium size category, indicate by entering a zero.
- ITEM 5:** Indicate the amount spent for providing Accident & Illness Prevention Services, during the period covered by this report, rounded to the nearest dollar. Include costs associated with preparation, travel, and on-site surveys/recommendations. **DO NOT** include overhead costs such as insurer or contracted personnel training, underwriting surveys or account introductory visits. **DO NOT** include expenses declared on *Special Schedule W*, Parts A-1 thru A-5, Item 12A as filed with the Pennsylvania Department of Insurance.

# Instructions for Completing Form LIBC-2101

## INSURER'S ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

- ITEM 6:** Check (✓) "yes" if you charge for Accident & Illness Prevention Services provided in excess of those which are included as a component of the policyholder's standard premium. If, for example, specialized services such as laboratory analysis, or special studies are required.
- ITEM 7:** Indicate the number of requests for Accident & Illness Prevention Services, that have been received from policyholders within the Commonwealth of Pennsylvania, during the period covered by this report. Indicate no request for Accident & Illness Prevention Services being received by entering a (0) zero.
- ITEM 8:** Indicate the number of requests for Accident & Illness Prevention Services, that have been fulfilled and brought to closure via an on-site inspection or completion of another requested activity, during the period covered by this report. Indicate no request for Accident & Illness Prevention Services being fulfilled by entering a (0) zero.

**NOTE:** *Attach an explanation if the number of requests received and fulfilled as reported in Item #8 is less than the reported number of requests received in Item #7. Mark the attachment as Item #8.*

- ITEM 9a:** Indicate "yes" if a notice of Accident & Illness Prevention Services, as required by Article X, accompanies each Workers Compensation Insurance Policy delivered or issued within the Commonwealth of Pennsylvania. **NOTE:** The *Pennsylvania Workers' Compensation Act* [Section 1001 (d)] requires that; "insurers notify policyholders of the availability of services and that the notice accompany each workers' compensation insurance policy delivered or issued for delivery in this Commonwealth". Attach a sample copy of the notification that accompanies each workers' compensation insurance policy delivered or issued for delivery in this Commonwealth. Please use an attached sheet identified as ITEM 9a.
- ITEM 9b:** Indicate "yes" if the policyholders notification appears in no less than 10 point bold type. The *Pennsylvania Workers' Compensation Act* [Section 1001 (d)] requires that the policyholder notification referred to under ITEM 9a above; must appear in no less than 10 point bold print.
- ITEM 10:** Check (✓) the method(s) utilized for determining services commitments. Methods could include, but not be limited to (a) policyholder request; (b) loss history; (c) loss ratio (**incurred losses ÷ earned premium**) (d) incurred losses; (e) paid losses; (f) requests by underwriters as a component of coverage; (g) requests by brokers as an account agreement; (h) insurer schedule by policyholder SIC Code; (i) experience modification factor: a factor developed by the Pennsylvania Compensation Rating Bureau that apportions the cost of workers' compensation insurance based upon losses reported, a modifier of < 1 usually indicates favorable loss experience, while a modifier > 1 suggests worse than average loss experience; or (j) other method, please use an attached explanation identified as ITEM 10j for all other methods used to determine Accident & Illness Prevention Service Commitments.
- ITEM 11:** Indicate in Column I the type(s) of Accident & Illness Prevention Services that are **maintained or provided** for policyholders. Indicate in Column II and/or Column III whether insurers in-house qualified employee services providers, or qualified contracted services providers, provide these services. Indicate in Column IV the number of each service provided during period covered by this

# Instructions for Completing Form LIBC-210I

## INSURER'S ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

- ITEM 12a and 12b:** Indicate the number of **Qualified** Accident & Illness Prevention Service Providers, both insurer employees and contracted personnel, who are directly involved in the delivery of Accident & Illness Prevention Services to policyholders within the Commonwealth of Pennsylvania. Include the total number of both full-time and part-time Employee Provider(s) and Contracted Providers that provided Accident & Illness Prevention Services and/or were available to provide Accident & Illness Prevention Services during the period covered by this report.
- ITEM 13:** If Accident & Illness Prevention Materials are provided to policyholders, indicate with an (X) the type(s) that are provided.
- ITEM 14:** Indicate with an (X) the internal method(s) utilized to determine the effectiveness of Accident & Illness Prevention Services. Methods could include, but are not limited to: (a) comparisons of incidence rates as calculated by the policyholder or the insurer; (b) submitted recommendations that are considered closed; (c) comparisons of the number of incurred or paid losses for a specific period; (d) results of customer satisfaction surveys; (e) comparisons of loss ratios for a specific period; (f) experience modification factor (g) other method, please explain using an attached sheet identified as ITEM 14g.
- ITEM 15:** Provide Contact Person information, if the individual to be contacted about information reported is different from the person signing the report.
- ITEM 16a and 16b:** - is to be used for the reporting of Accident & Illness Prevention Service Providers that hold one of the current recognized certifications/designations, that have not been previously reported and assigned a Provider I.D. #, and for new requests for In-Service Status. Provide the full and complete First, Middle, and Last Name. Indicate if Service Provider is an employee or contracted. If the Service Provider is qualified, enter the number corresponding with the recognized qualification(s) listed below. Enter the date when the service provider began providing Accident & Illness Prevention Services. (This date should be the date the individual began employment in the Accident & Illness Prevention Field.) List up to three Primary Accident & Illness Prevention services that the Individual provides. Indicate with an (X) in one of the two request boxes indicating if the request is for Qualified recognition or In-Service Status.

**EXAMPLE:** the Accident & Illness Prevention Service Provider has been Certified as a Safety Professional. Indicate in Roman Numeral (i) by entering (03) **NOTE: use a (0) in front of qualifications represented by a single digit.**

**Categories:** To be qualified as an Accident & Illness Prevention Service Provider within the meaning of Section 1001(a) of the Act (7 P.S. §1038.1(a). A person shall obtain one or more of the following qualifications and have two years of acceptable safety experience. Proof of Qualification of the Accident & Illness Prevention Service Provider(s) is the responsibility of, and must be maintained by the organization for which the Accident & Illness Prevention Service Provider(s) are employed by, or contracted by to provide Accident & Illness Prevention Service. Acceptable proof of qualification includes; copies of registration or certification cards, certificates, and certified transcripts.

# Instructions for Completing Form LIBC-210I

## INSURER'S ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

### **Accident & Illness Prevention Service Provider Qualifications.**

To be qualified as an Accident & Illness Prevention Service Provider within the meaning of Section 1001(a) of the Act (7 P.S. §1038.1(a) and this Chapter, a person shall obtain one or more of the following qualifications **and have two years of acceptable safety experience.**

- (01) Certification as a Medical Doctor (M.D.) in Occupational Medicine granted by the American Board of Preventive Medicine (ABPM).
- (02) Certification as an Industrial Hygienist (CIH) granted by the American Board of Industrial Hygiene (ABIH).
- (03) Certification as a Safety Professional (CSP) granted by the Board of Certified Safety Professionals (BCSP).
- (04) Certification as an Industrial Hygienist in Training (IHIT) granted by the American Board of Industrial Hygiene (ABIH).
- (05) Certification as an Associate Safety Professional (ASP) granted by the Board of Certified Safety Professionals (BCSP).
- (06) A Bachelor's Degree, Master's Degree or Doctoral Degree in safety earned from an accredited program within an accredited college or university.
- (07) A Bachelor's Degree, Master's Degree or Doctoral Degree in science or engineering with a major or concentration in occupational/industrial safety and health from an accredited program within an accredited college or university.
- (08) Certification as an Occupational Health Nurse (COHN) granted by the American Board for Occupational Health Nurses (ABOHN).
- (09) Certification as an Occupational Health and Safety Technologist (COHST) granted by the American Board of Industrial Hygiene (ABIH), Board of Certified Safety Professional (BCSP) Joint Committee.
- (10) An Advanced Safety Certificate earned from the National Safety Council's Safety Training Institute.
- (11) An Associate in Loss Control Management (ALCM) earned from the Insurance Institute of America (IIA).
- (12) An Associate Risk Management (ARM) earned from the Insurance Institute of America (IIA).
- (13) Certification as a Safety Executive (WSO-CSE), Safety Manager (WSO-CSM), or Safety Specialist (WSO-CSS) granted by the World Safety Organization (WSO).
- (14) Certification as a Professional Ergonomist (CPE) granted by the Board of Certification of Professional Ergonomist (BCPE).

# Instructions for Completing Form LIBC-210I

## INSURER'S ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES

**In-Service Status:** A person who is currently employed by an insurer, individual self-insured employer, or group self-insurance fund, to provide Accident & Illness Prevention Services and who does not possess any Bureau recognized qualifications as outlined in Section IV, shall have five (5) years to meet one or more of the qualifications, in order to continue to provide Accident & Illness Prevention Services for the current or subsequent insurer, self-insured employer, or group self-insurance fund. Individuals reported and granted In-Service Status are required to be under the direction of a service provider currently holding a recognized qualification during the five (5) year period in which a recognized credential is being earned. After that five (5) year period, any individual who has not obtained a recognized qualification and submitted acceptable proof to the Bureau, will not be permitted to provide Accident & Illness Prevention Services for the current or any subsequent insurer, self-insured employer, or group self-insurance fund, until a recognized qualification is obtained.

New requests for In-Service status must include their full name (to include full middle name/middle initial if applicable), date they began providing Accident & Illness Prevention Services, their primary service that they provide, and "New Requests for In-Service" marked under In-Service Status.

**ITEM 17:** Report the Accident & Illness Prevention Service Provider I.D. number for Accident & Illness Prevention Service Providers that have previously been granted In-Service status, recognized based on Experience, or who possess a recognized Qualification, whose services were utilized during this report period, or were available to provide Accident & Illness Prevention Services, during this report period..

Indicate the Hiring status of each Accident & Illness Prevention Service Provider reported. Use an "E" to represent an Employee Service Provider of the insurer, and a "C" to represent Contracted Service Provider.

Fill in the last name, first name and middle initial of each Service Provider reported.

**NOTE:** *This report must be signed on page 1. An original signature is required. Provide the first name, middle initial, last name, title, telephone number, and the date the report is signed.*

( \* \* \* )

**Page 2 - Individual Self-Insured Employers Accident & Illness Prevention Program Annual Report**

7. Which of the Following Method(s) are Used to Determine the Effectiveness of the Accident & Illness Prevention Program [check (✓) method(s) used]: **For the Method(s) Used, Please Supply the Information Requested.**

( ) I. OSHA/BLS Incidence Rate Comparison By the Standard Industrial Classification (SIC) Code

*Please State Incidence Rate:*

- a. Prior Fiscal Year \_\_\_\_\_
- b. One Year Prior to Last Fiscal Year \_\_\_\_\_
- c. Two Years Prior to Last Fiscal Year \_\_\_\_\_

( ) II. Comparison of Statistics Derived from "First Reports"

*Please State Your Injury and Illness Rate Using the FORMULA in the Instructions:*

- a. Prior Fiscal Year \_\_\_\_\_
- b. One Year Prior to Last Fiscal Year \_\_\_\_\_
- c. Two Years Prior to Last Fiscal Year \_\_\_\_\_

( ) III. Experience Modification Factor or Loss Ratio

*Please State Your Experience Modification Factor or Loss Ratio as Per the Instructions:*

	<b><u>E-MOD FACTOR</u></b>	<b><u>LOSS RATIO</u></b>
a. Prior Fiscal Year	_____	_____
b. One Year Prior to Last Fiscal Year	_____	_____
c. Two Years Prior to Last Fiscal Year	_____	_____

( ) IV. Other [Explain - Identify as Item #7 (IV) on additional sheets]

I, the undersigned, verify that the facts set forth in this report and any attachments are true and correct. This verification is made subject to the penalties of Section 4904 of the *Crimes Code*, 18 Pa.C.S. §4904, relating to unsworn falsification to authorities.

\_\_\_\_\_  
Name/Contact (please print)\*\*

\_\_\_\_\_  
Title

( ) \_\_\_\_\_  
Telephone

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***(Please Attach Additional Sheets, Where Necessary, Labeled With Appropriate Form Section Number and Letter)***

**Send this Completed Report and the Documentation of Qualifications for Accident & Illness Prevention Services Provider(s) (DOQ) Affidavit along with your Self-Insurance Renewal Application to:**

Pennsylvania Bureau of Workers' Compensation  
Health and Safety Division  
1171 South Cameron Street, Room 324  
Harrisburg, PA 17104-2501  
(717) 772-1636

(\*\*Name/Contact and Telephone Number of Person Signing this Form and Who Can Provide Additional Information)

# Instructions For Completing Form LIBC-220E

## ANNUAL REPORT OF ACCIDENT & ILLNESS PROGRAM STATUS BY INDIVIDUAL SELF-INSURED EMPLOYERS

This Form must be filed with the Bureau of Workers' Compensation, Self-Insurance and Safety Division for the most recent completed fiscal year preceding the submission of the Self-Insured Employer's Annual Renewal Application.

**NOTE:** The term **Accident & Illness Prevention Services** as described in the **Pennsylvania Workers' Compensation Act** is synonymous with the terms ***Safety and Health Program, and Loss Control Program.***

**FEIN, BUREAU CODE/SELF- INSURANCE CODE:** Your assigned Federal Employers Identification Number and the one to four digit Bureau Code/Self-Insurance Code assigned to you by the Bureau of Workers' Compensation.

- ITEM 1:** The full name of the self-insured employer as registered with the Commonwealth of Pennsylvania and the Bureau Code for the employer. Please insert any corrections to this information.
- ITEM 2:** The address of the self-insured employer as registered with the Self-Insurance and Safety Division. Please insert any corrections to this information including the proper address for future mailings from the Department.
- ITEM 3:**
- (a) State the total number of physical locations, where employees are present on a daily basis, operated by the self-insured employer within the Commonwealth of Pennsylvania during the prior fiscal year; and
  - (b) State the total number of employees at such locations.
- ITEM 4:** Check (✓) "yes" or "no". A goal may be a 25% reduction in the number of recordable injuries (OSHA definition) during a specific period; while an objective could be the improvement of manual material handling tasks.
- ITEM 5:** Check (✓) the elements contained within the Accident & Illness Prevention Program developed, implemented and monitored by the self-insured employer (employer). If "other", please describe work site specific procedures using an attached sheet identified as ITEM 5. Elements 5 (a) thru (n) are considered mandatory by the Pennsylvania Workers' Compensation Act, while the procedures and activities described in 5 (o) are applicable only on an individual employer need basis. The following definitions apply to the specific Program elements:
- (a) Statement regarding the Accident & Illness Prevention philosophy of the self-insured employer that serves as a foundation for all program activities. This statement is signed by the Chief Executive Officer and is communicated to all employees.

# **Instructions For Completing Form LIBC-220E**

## **ANNUAL REPORT OF ACCIDENT & ILLNESS PROGRAM STATUS BY INDIVIDUAL SELF-INSURED EMPLOYERS**

### **ITEM 5: (CONT'D.)**

- (b) Individual appointed by the employer to coordinate the provision of Accident & Illness Prevention Services by location or on a corporate basis.
- (c) Assignment of Accident & Illness Prevention Program functions to both services providers and other responsibilities to employer personnel.
- (d) System for conducting hazard identification and control assessments and for providing recommendations or suggestions for the purpose of eliminating or reducing occupational accidents, injuries and illnesses. Activities may include, but not be limited to: providing solutions, explanations, resources, reference materials and referrals.
- (e) Services that include an initial consultation concerning the physical, mental and social well being of people in relation to their job and working environment. These consultation may produce recommendations designed to identify, control, and/or eliminate health hazards and are used toward implementing a program of Accident & Illness Prevention Services.
- (f) Services that include surveys and consultations concerning suspected chemical, physical or biological exposures. These surveys and consultations may produce recommendations designed to control and/or prevent, identified exposures and are directed towards implementing a program of Accident & Illness Prevention Services.
- (g) Learning experiences which enable employers and/or employees to enhance their knowledge and skills, attitudes, and motivations concerning health and safety requirements relating to operations, processes, and specific work environments. Included is training for management and labor safety committee members regarding their roles and responsibilities.
- (h) A plan designed to provide a quick and pre-planned response to emergencies or unexpected or disastrous events that include, but are not limited to fires, floods, gas leaks, and ordered evacuations.
- (i) A system whereby employees can offer recommendations that are expected to improve the overall Accident & Illness Prevention Program or improve related operating conditions.

# **Instructions For Completing Form LIBC-220E**

## **ANNUAL REPORT OF ACCIDENT & ILLNESS PROGRAM STATUS BY INDIVIDUAL SELF-INSURED EMPLOYERS**

### **ITEM 5: (CONT'D.)**

- (j) A program whereby all employees are able to participate in Accident & Illness Prevention Program projects and activities, including assumption of certain Program responsibilities, either on an assigned, or voluntary basis.
- (k) Specifications regulating workplace and job performance behaviors and practices. Rules may be a result of legislative mandates and/or policies developed by the employer for specific site and task application.
- (l) Procedure for timely investigation of accidents, analysis of cause(s), completion of required reporting and recording, and a system for monitoring this information.
- (m) A program of services for providing immediate care to an injured or suddenly ill employee. This program includes on-site services, as well as those provided by the medical community.
- (n) Method for assuring the quality of the Accident & Illness Prevention Program Services. Different than effectiveness measures, this element would involve actual review and critique of the Program for the purpose of determining the strength and weaknesses of its components, as well as Program areas that may require revision.
- (o)(1) Systems, programs, procedures, hardware and equipment installed upon, around, over, or near any machine or electrical installation so as to eliminate accidental contact by any person with the hazardous mechanical and/or electrical components.
- (o)(2) Devices and apparel worn by the worker to protect against hazards in the work environment.
- (o)(3) Program established to reduce or eliminate, if possible, the level of noise in the work environment to safe levels through engineering controls, administrative control and/or personal protective equipment.
- (o)(4) Program established to reduce or eliminate, if possible, any physical or environmental hazards to employees eyes. Methods may include personal protective eye wear, goggles, face shields, point of operation equipment guards, non-hazardous tools, proper illumination, and other similar engineering controls.

# Instructions For Completing Form LIBC-220E

## ANNUAL REPORT OF ACCIDENT & ILLNESS PROGRAM STATUS BY INDIVIDUAL SELF-INSURED EMPLOYERS

### ITEM 5: (CONT'D.)

(o)(5) A program consisting of an energy control procedure and employee training to ensure that a machine or equipment is isolated, de-energized and completely inoperative (locked out) before servicing or maintenance, thus protecting the employee from unexpected machine start-up or release of stored energy source..

(o)(6) A program of identifying and controlling the receipt, use, storage and disposal of hazardous chemicals and products containing hazardous chemicals. Included is development of a chemical inventory, procurement of material safety data sheets (MSDS) and training for employees in identifying hazardous materials, understanding possible exposures and routes of entry of the chemical into the body, knowledge of the signs and symptoms of overexposure, and recommended first-aid procedures if overexposure should occur. This also includes the provisions of the *Pennsylvania Worker and Community Right to Know Act*, Pennsylvania Law 743, Number 159 for non-manufacturing employers.

(o)(7) A program of required procedures which must be followed when entering, for any reason, any area that has limited openings for entry and exit that would make escape difficult in an emergency, has a lack of ventilation, contains known and potential hazards, or is neither intended nor designed for continuous human occupancy.

(o)(8) A program or required procedures for the prevention and control of fires and their related cause factors. Also includes methods for responding to fires should they occur, employee evacuation procedures, and other applicable techniques for protecting life and property.

(o)(9) A program of requirements for protecting employees against the hazards related to exposure to blood or other potentially infectious body fluids. This also includes employee training and a procedure for immediate follow-up should an exposure incident occur.

(o)(10) Review of plans, drawings, diagrams and specifications for processes, equipment and machinery prior to their introduction and use in the workplace. This review is for the purpose of identifying and correcting hazardous conditions.

(p) If other work site specific programs, procedures, or activities are in place, please describe on an additional sheet identified as ITEM 5 (p).

# Instructions For Completing Form LIBC-220E

## ANNUAL REPORT OF ACCIDENT & ILLNESS PROGRAM STATUS BY INDIVIDUAL SELF-INSURED EMPLOYERS

**ITEM 6:** State the number of **Qualified** Accident & Illness Prevention Providers, both employees of the self-insured employer and contracted personnel who are directly involved in the delivery of Accident & Illness Prevention Services in locations within the Commonwealth of Pennsylvania. Include both full and part-time personnel and contracted personnel who may, or may not have been called upon to provide services during the report year. Please attach copies of Form LIBC-240Q, Documentation of Qualifications for Accident & Illness Prevention Services Provider(s). See Page 4 of the Documentation of Qualifications Affidavit for a complete list of accepted qualifications for Accident & Illness Prevention Providers.

**ITEM 7:** Indicate the internal method(s) utilized to determine the effectiveness of the Accident & Illness Prevention Program. State the applicable rates for the prior full fiscal year and one and two years prior to the last full fiscal year. Calculation methods include:

**Section I:** Comparisons of your incidence rate using the OSHA/Bureau of Labor Statistics (BLS) formula: **number of recordable injuries x 200,000 ÷ hours worked**, and then comparing your incidence rate to the OSHA/Bureau of Labor Statistics (BLS) published incidence rate for your business or industry; **OR**

**Section II:** Comparison of your injury and illness rate derived via the *Employer's Report of Occupational Injury or Disease (Form LIBC-344, Rev. 8-93)*, using the formula: **number of "First Reports" filed x 1,000 ÷ average number of employees**, and then comparing your rate to the rates published in the current edition of *Pennsylvania Work Injuries and Illnesses*, Table 2, "Injury and Illness Rates In Selected Industries"; **OR**

**Section III:** State the experience modification factor or loss ratio for the entire fiscal year and compare these rates to the previous two years; **OR** If another method is utilized, please check (✓) **Section IV** and attach a separate sheet identified as ITEM 7 (IV), to describe the method(s).

**NOTE 1:** *Since it may be necessary to clarify information reported, the person responsible for completing this report should be listed on the Contact line and his/her telephone number included. Also, the person signing this Report must be authorized to do so by an Officer of the company or corporation. The company or corporation assumes ultimate responsibility of the accuracy of responses contained herein.*

**(PLEASE USE ADDITIONAL SHEETS WHERE NECESSARY)**

**COMMONWEALTH OF PENNSYLVANIA  
INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION PROGRAM  
STATUS BY NEW GROUP SELF-INSURANCE FUNDS**

*This Report Must be Included With the Application to Operate as a Group Workers' Compensation Fund and Submitted to the Pennsylvania Bureau of Workers' Compensation, Self-Insurance and Safety Division.*

(Please type or print all information. Before completing, please refer to the accompanying instructions regarding items #1 through # 10)

**Application Date** \_\_\_\_\_

1. Proposed Fund Name: (Please see Instructions on Page 4)

2. Mailing Address: (Street, P.O. Box, City, State, Zip Code)

3. Total Number of Members to be Affiliated with the Group Self-Insurance Fund: \_\_\_\_\_

4. What methods will be utilized for determining program services commitments [Check (✓) all that apply]:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> a. Member Contribution (%) | <input type="checkbox"/> e. Incidence Rate    | <input type="checkbox"/> i. Fund Administrator Request  |
| <input type="checkbox"/> b. Request                 | <input type="checkbox"/> f. First Report Rate | <input type="checkbox"/> j. Annual Inspection           |
| <input type="checkbox"/> c. Request Only            | <input type="checkbox"/> g. Incurred Losses   | <input type="checkbox"/> k. Other [Explain /Identify as |
| <input type="checkbox"/> d. Loss History            | <input type="checkbox"/> h. Paid Losses       | Item 4(k) on additional sheets]                         |

5. Based on the current plan, state the elements that will be contained within the Fund's Accident & Illness Prevention Program at the time the Fund is approved [check (✓) all that apply]:

- |   |   |
|---|---|
| <input type="checkbox"/> a. Safety Program Policy Statement<br><input type="checkbox"/> b. Safety Program Coordinator Designated<br><input type="checkbox"/> c. Safety Program Responsibility Assignments<br><input type="checkbox"/> d. Safety Program Goals and Objectives<br><input type="checkbox"/> e. Hazard Identification Methods<br><input type="checkbox"/> f. Industrial/Occupational Health Services<br><input type="checkbox"/> g. Industrial Hygiene Services<br><input type="checkbox"/> h. Accident & Illness Prevention Program Training<br><input type="checkbox"/> i. Emergency Action Plan<br><input type="checkbox"/> j. Employee Safety Suggestion Program<br><input type="checkbox"/> k. Employee Involvement Methods<br><input type="checkbox"/> l. Safety Rules and Enforcement Procedure<br><input type="checkbox"/> m. Accident Investigation and Reporting<br><input type="checkbox"/> n. Availability of First-Aid & CPR<br><input type="checkbox"/> o. Program Evaluation Methods | <input type="checkbox"/> p. Work Environment Procedures Relating to:<br><input type="checkbox"/> 1. Electrical and Machine Guarding<br><input type="checkbox"/> 2. Personal Protective Equipment<br><input type="checkbox"/> 3. Hearing Conservation Program<br><input type="checkbox"/> 4. Vision Conservation Program<br><input type="checkbox"/> 5. Lock-Out Tag-Out Program<br><input type="checkbox"/> 6. Hazardous Material & Waste Program<br><input type="checkbox"/> 7. Confined Space Entry Program<br><input type="checkbox"/> 8. Fire Prevention & Protection Program<br><input type="checkbox"/> 9. Bloodborne Pathogens Exposure Control<br><input type="checkbox"/> 10. Pre-Operational Process Review<br><input type="checkbox"/> q. Other Worksite Specific Procedures/Describe<br>[Explain - Identify as Item #5 (q) on additional sheet] |
|---|---|

**Page 2- Initial Report of Accident & Illness Prevention Program Status by New Group Self-Insurance Funds**

6. Indicate the number of qualified personnel the Fund plans on utilizing to provide Accident & Illness Prevention Program services (Fund Personnel or Contracted)

a. Fund Personnel

b. Contract Personnel

7. State the types of Accident & Illness Prevention Materials that the Fund intends to provide to it's members:  
[Check (✓) the types of materials to be provided]:

- |  |  |
|--|--|
| <input type="checkbox"/> a. Audiovisual Materials            | <input type="checkbox"/> f. Sample Programs  |
| <input type="checkbox"/> b. Posters/Payroll Stuffers         | <input type="checkbox"/> g. Awards   |
| <input type="checkbox"/> c. Booklets, Brochures or Pamphlets | <input type="checkbox"/> h. Other [Explain /Identify as Item # 7(h)<br>on additional sheets] |
| <input type="checkbox"/> d. Regulations/Standards            |  |
| <input type="checkbox"/> e. Sample Forms                     |  |

8. Which of the following method(s) will be used to determine the effectiveness of the Fund's Accident & Illness Prevention Program [check (✱) the method(s) used]:

- ☐ I. OSHA/BLS Incidence Rate Comparison By the Standard Industrial Classification (SIC) Code
- ☐ II. Comparison of Statistics Derived form "First Report"
- ☐ III Experience Modification Factor or Loss Ratio
- ☐ IV. Other [Explain-Identify as Item #10(IV) on additional sheets]

I, the undersigned, verify that the facts set forth in this report and any attachments are true and correct. This verification is made subject to the penalties of *Section 4904 of the Crime Codes, 18 Pa. C.S. Subsection 4904*, relating to unsworn falsification to authorities.

_____ Point of Contact Name (please print)**	_____ Title	_____ ( ) Telephone
_____ Signature	_____ Date	

(\*\* Contact Person Name and Telephone Number of Person Signing this Form is Necessary in case Additional Information is Needed)

Send this Completed Report along with your Application to Operate as a Group Workers' Compensation Fund to:

Pennsylvania Bureau of Workers' Compensation  
Self-Insurance & Safety Division Room 324  
Health & Safety Section  
1171 South Cameron Street  
Harrisburg, PA 17104-2501  
(717) 772-1636

***(Please Attach Additional Sheets, Where Necessary, Labeled With  
Appropriate Form Section Number and Letter)***

**INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION PROGRAM STATUS  
BY NEW GROUP SELF-INSURANCE FUNDS**

This Form must be filed with the Bureau of Workers' Compensation, Self-Insurance & Safety Division along with the Application to Operate as a Group Workers' Compensation Fund.

**NOTE:** The term **Accident & Illness Prevention Program** as described in the *Pennsylvania Workers' Compensation Act* is synonymous with the terms **Safety and Health Program** and **Loss Control Program**.

- ITEM 1:** State the full name of the Group Self-Insurance Fund as it will be registered with the Self-Insurance & Safety Division
- ITEM 2:** The address of the Group Self-Insurance Fund as registered with the Self-Insurance & Safety Division.
- ITEM 3:** State the total number of members affiliated with the fund at the time application is made to Self-Insurance & Safety Division.
- ITEM 4:** Describe the method(s) that will be used in promoting Accident & Illness Prevention Program Services and/or reasons for lack of promotion. Include an attached sheet identified as ITEM 4.
- ITEM 5:** Check the elements that will be contained within the Accident & Illness Prevention Program offered by the fund. Items (a) through (o) are considered to be the minimum acceptable elements that the Fund is required to have for the Fund members. Elements listed under (p) are considered as required based on the nature of the Funds business. The following definitions apply to the specific program elements:
- (a) A statement regarding the Accident & Illness Prevention philosophy of Fund management that serves as a foundation for all program activities. This statement is signed by the Fund Manager and is communicated to all members. This statement may also be modified by any member for the purpose of establishing an individual member policy statement.
  - (b) Individual(s) appointed by the Fund to coordinate the function of Accident & Illness Prevention Program. Individual members should also appoint such an individual at their location to oversee their site specific program.
  - (c) Assignment of Accident & Illness Prevention Program responsibilities to Fund personnel, including both employees and contracted personnel available to provide services to Fund members on behalf of the Fund.
  - (d) A statement or description explaining how Accident & Illness Prevention Program goals and objectives will be set.
  - (e) System for conducting hazard identification and control assessments and for providing recommendations or suggestions to members for the purpose of eliminating or reducing occupational accidents, injuries and illnesses. Activities may include, but not be limited to: providing solutions, explanations resources, reference materials and referrals.

**INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION PROGRAM STATUS  
BY NEW GROUP SELF-INSURANCE FUNDS**

- (f) Services that include initial consultations concerning the physical, mental and emotional well-being of employees in relation to their job and working environment. These consultation may produce recommendations designed to identify, control and/or eliminate health hazards.
- (g) Services that include surveys and consultations concerning suspected chemical, physical or biological exposure. These surveys/consultations may produce recommendations designed to control, reduce and/or prevent , identified exposure.
- (h) Learning experiences which enable the Fund and its members to enhance knowledge and skills, attitudes and motivations concerning health and safety procedures relating to operation, processes and specific work environments. Included is training for mangement/labor safety committee members regarding their roles and responsibilities.
- (i) A plan an designed to provide a quick and pre-planned response to emergencies or unexpected or disastrous events that include, but are not limited to fires, floods, gas leaks and ordered evacuations.
- (j) A system whereby employees can offer recommendations that are expected to improve the overall Accident & Illness Prevention Program or improve related operating conditions.
- (k) A program whereby all employees are able to participate in Accident & Illness Prevention Program projects and activities, including assumption of certain program responsibilities, either on an assigned or voluntary basis.
- (l) Specifications regulating workplace and job performance behaviors and practices. Rules may be a result of legislative mandates and/or policies developed by the employer for specific site and task application.
- (m) Procedures for timely investigation of accidents, analysis of cause(s), completion of required reporting and recording, and a system for monitoring this information.
- (n) A program of services for providing immediate care to an injured or suddenly ill employee. This includes on-site services, as well as those provided by the medical community.
- (o) Method for assuring the quality of Accident & Illness Prevention Program Services. Different than effectiveness measures, this element would involve actual review and critique of the program for the purpose of determining the strength and weaknesses of it's components, as well as program areas that may require revision.

**INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION PROGRAM STATUS  
BY NEW GROUP SELF-INSURANCE FUNDS**

- (p)(1) Systems, programs, procedures, hardware and equipment installed upon, around, over or near any machine or electrical installation so as to eliminate accidental contact by any person with the hazardous mechanical and/or electrical components.
- (p)(2) Devices and apparel worn by the worker to protect against hazards in the work environment.
- (p)(3) A program established to reduce or eliminate, if possible, the level of noise in the work environment to safe levels through engineering controls, administrative controls and/or personal protective equipment.
- (p)(4) A program established to reduce or eliminate, any physical or environmental hazards to employees eyes. Methods may include personal protective equipment (safety glasses, goggles, and face shields), point of operation equipment guards, nonhazardous tools, proper illumination, and other similar engineering controls.
- (p)(5) A program consisting of an energy control procedure and employee training to ensure that a machine or equipment is isolated or inoperative (locked out) before servicing or maintenance takes place, thus protecting the employee from unexpected startup or energizing of machinery or equipment..
- (p)(6) A program identifying and controlling the receipt, use, storage and disposal of hazardous chemicals and products containing hazardous chemicals. Included is the development of a chemical inventory, procurement of material safety data sheets (MSDS) and training for employees in identifying hazardous materials, understanding possible exposures and routes of entry of the chemical into the body, knowledge of the signs and symptoms of overexposure and recommended first-aid procedures should overexposure occur. This also includes the provisions of the *Pennsylvania Worker and Community Right to Know Act*, Pennsylvania Law 743, Number 159 for nonmanufacturing employers.
- (p)(7) A program of procedures and requirements to follow when entering, for any reason, any area that has limited openings for entry and exit that would make escape difficult in an emergency, has a lack of ventilation, contains known and potential hazards and is not intended nor designed for continuous human occupancy.
- (p)(8) A program of procedures and requirements for the prevention and control of fires and their related cause factors. Also includes methods for responding to fires should they occur, employee evacuation procedures and other applicable techniques for protecting life and property.
- (p)(9) A program of requirements for protecting employees against the hazards related to exposure to blood or other potentially infectious body fluids. This also includes employee training and a procedure for immediate follow-up should an exposure incident occur.
- (p)(10) Review of plans, drawings, diagrams and specifications for processes, equipment and machinery prior to their use and introduction into the workplace. This review is for the purpose of identifying and correcting hazardous conditions.

**INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION PROGRAM STATUS  
BY NEW GROUP SELF-INSURANCE FUNDS**

(q) If other work site specific programs, procedures or activities are in place, please describe on an additional sheet identified as ITEM 5(q).

**ITEM 6:** State the number of ***Qualified*** Accident & Illness Prevention Service Providers, both employees of the Fund and contracted personnel who will be directly involved in the delivery of Accident & Illness Prevention Services in locations within the Commonwealth of Pennsylvania. Include both full and part-time personnel and contracted personnel who may, or may not have been called upon to provide services during the report year.

**ITEM 7:** If Accident & Illness Prevention Materials will be provided to members, check (✓) the types that are or will be available.

**ITEM 8:** Indicate the internal method(s) to be utilized in determining the effectiveness of the Accident & Illness Prevention Program.

**I:** Comparisons of the Fund's incidence rate using the OSHA/Bureau of Labor Statistics (BLS) formula: **number of recordable injuries × 200,000 ÷ hours worked**, and then comparing the Fund's incidence rate to the OSHA/Bureau of Labor Statistics (BLS) published incidence rate for your business or industry; **OR**

**II:** Comparison of the Fund's injury and illness rate derived via the *Employer's Report of Occupational Injury or Disease (Form LIBC-344, Rev. 8-93)*, using the formula: **number of "First Reports" filed × 1,000 ÷ average number of employees**, and then comparing the fund's rate to the rates published in the current addition of *Pennsylvania Work Injuries and Illnesses*, Table 2, "Injury and Illness Rates In Selected Industries"; **OR**

**III:** State the Experience Modification Factor or Loss Ratio for the entire fiscal year and compare these rates to the previous two years; **OR**

If another method is utilized, please check ( ✓ ) **IV** and attach a separate sheet identified as ITEM #8 (IV), to describe the method(s).

**NOTE:** Since it may be necessary to clarify information reported, the person responsible for completing this report, or the person responsible for the operation of the Fund's Accident & Illness Prevention Program should be listed on the contact line and his/her telephone number included. Also, the person signing this report must be authorized to do so by an officer of the Fund. The Fund Administrator assumes ultimate responsibility of the accuracy of responses contained herein.

**(PLEASE USE ADDITIONAL SHEETS WHERE NECESSARY)**

**COMMONWEALTH OF PENNSYLVANIA  
ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION PROGRAM  
STATUS BY GROUP SELF-INSURANCE FUNDS**

*This Report Must be Included With the Annual Report Submitted to the Pennsylvania Bureau of Workers' Compensation Self-Insurance and Safety Division as Required by 77 P.S. §1036.15*

(Please print or type all information. Before completing, please refer to the accompanying instructions regarding Items #1 through #11.)

Report for Fund Year \_\_\_\_\_, 19\_\_ to \_\_\_\_\_, 19\_\_

**PLEASE MAKE ANY NECESSARY CORRECTIONS TO INFORMATION IN ITEMS #1 AND #2**

Bureau Code (Self-Insurance Code):

--	--	--	--

1 Fund Name (Please See Instructions on Page 4)

2 Mailing Address Street, P O Box, City State Zip Code

3 Total Number of Members Affiliated with the Group Self-Insurance Fund

\_\_\_\_\_

3a Total Number of Members Receiving Accident & Illness Prevention Services

\_\_\_\_\_

3b Total Amount Spent on Accident & Illness Prevention Program Services

\_\_\_\_\_

4 Total Number of Requests for Accident & Illness Prevention Program Services Received

\_\_\_\_\_

4a Total Number of Requests for Services that were Fulfilled

\_\_\_\_\_

4b Number of Member Service Requests Fulfilled Via Service Visits

\_\_\_\_\_

5 Is the Availability of Program Services Promoted ( ) Yes ( ) No

6 Method(s) Utilized for Determining Program Services Commitments [check (✓) all that apply]

- ( ) a Member Contribution (%)  
( ) b Member Request  
( ) c Loss History  
( ) d Incidence Rate

- ( ) e First Report Rate  
( ) f Incurred Losses  
( ) g Paid Losses  
( ) h Fund Administrator Request

- ( ) i Annual Inspection  
( ) j Other [Explain - Identify as Item #6(j) on additional sheets]

7 Number of On-Site Inspections Performed

\_\_\_\_\_

a By Fund Personnel

\_\_\_\_\_

b By Contracted Personnel

\_\_\_\_\_

**Page 2 - Group Self-Insurance Funds Accident & Illness Prevention Program Annual Report**


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8. State the Elements Contained Within Your Accident & Illness Prevention Program [check (, ) all that apply]:

- |  |  |
|--|--|
| <input type="checkbox"/> a. Safety Program Policy Statement                | <input type="checkbox"/> o. Work Environment Procedures Relating to: |
| <input type="checkbox"/> b. Safety Program Coordinator Designated          | <input type="checkbox"/> 1. Electrical and Machine Guarding          |
| <input type="checkbox"/> c. Safety Program Responsibilities Assignments    | <input type="checkbox"/> 2. Personal Protective Equipment            |
| <input type="checkbox"/> d. Hazard Identification Methods                  | <input type="checkbox"/> 3. Hearing Conservation                     |
| <input type="checkbox"/> e. Industrial/Occupational Health Services        | <input type="checkbox"/> 4. Vision Conservation                      |
| <input type="checkbox"/> f. Industrial Hygiene Services                    | <input type="checkbox"/> 5. Lockout/Tagout (Energy Isolation)        |
| <input type="checkbox"/> g. Accident & Illness Prevention Program Training | <input type="checkbox"/> 6. Hazardous Materials                      |
| <input type="checkbox"/> h. Emergency Action Plan                          | <input type="checkbox"/> 7. Confined Space Entry                     |
| <input type="checkbox"/> i. Employee Safety Suggestion Program             | <input type="checkbox"/> 8. Fire Prevention and Protection           |
| <input type="checkbox"/> j. Employee Involvement Methods                   | <input type="checkbox"/> 9. Bloodborne Pathogen Exposure Control     |
| <input type="checkbox"/> k. Safety Rules                                   | <input type="checkbox"/> 10. Pre-Operational Process Review          |
| <input type="checkbox"/> l. Accident Investigation and Reporting           | <input type="checkbox"/> p. Other Worksite Specific Procedures       |
| <input type="checkbox"/> m. Availability of First-Aid & CPR                | [Explain - Identify as Item #8 (p) on additional sheets]             |
| <input type="checkbox"/> n. Effectiveness Evaluation Methods               |  |

---

9. Number of <b>Qualified</b> Accident & Illness Prevention Providers Utilized to Provide Program Services:	a. Staff Personnel	b. Contracted Personnel
[Please Attach Form LIBC-240Q, <i>Documentation of Qualifications Affidavit for Accident &amp; Illness Prevention Services Provider for total entered for 9a and 9b</i> ]	_____	_____

---

10. State the Types of Accident & Illness Prevention Materials Provided to Members:

Check (✓) the Types of Materials Provided:

- |  |   |
|--|---|
| <input type="checkbox"/> a. Audio-visual Material          | <input type="checkbox"/> f. Sample Programs   |
| <input type="checkbox"/> b. Posters Payroll Stuffers       | <input type="checkbox"/> g. Awards  |
| <input type="checkbox"/> c. Booklets, Brochures, Pamphlets | <input type="checkbox"/> h. Other [Explain - Identify as Item #10(h) on additional sheets]      |
| <input type="checkbox"/> d. Regulations Standards          | <input type="checkbox"/> i. <i>Optional: What is the Total Cost of These Materials: \$_____</i> |
| <input type="checkbox"/> e. Sample Forms                   |   |

---

11. Which of the Following Method(s) are Used to Determine the Effectiveness of the Accident & Illness Prevention Services Program?  
[check (✓) method (s) used]: **For the Method (s) Used, Please Supply the Information Requested.**

☐ I. **OSHA/BLS Incidence Rate Comparison** (Please State Incidence Rate for the Fund)

- |  |       |
|--|-------|
| a. Prior Fund Year                       | _____ |
| b. One Year Prior to Last Fund Year      | _____ |
| c. Two Years Prior to Last Fund Year     | _____ |
| d. Number of Members Above OSHA/BLS Rate | _____ |
| e. Number of Members Below OSHA/BLS Rate | _____ |
-

**Page 3 - Group Self-Insurance Funds Accident & Illness Prevention Program Annual Report****( ) II. Comparison of Statistics Derived from "First Reports" (Please State Your Illness and Injury Rate Using the FORMULA in the Instructions)**

- a. Prior Fund Year \_\_\_\_\_
- b. One Year Prior to Last Fund Year \_\_\_\_\_
- c. Two Years Prior to Last Fund Year \_\_\_\_\_
- d. Number of Members Above State Specific Rate \_\_\_\_\_
- e. Number of Members Below State Specific Rate \_\_\_\_\_

**( ) III. Experience Modification Factor or Loss Ratio (Please State Your Experience Modification Factor or Loss Ratio as Per the Instructions)**

	<b><u>E-MOD FACTOR</u></b>	<b><u>LOSS RATIO</u></b>
a. Prior Fund Year	_____	_____
b. One Year Prior to Last Fund Year	_____	_____
c. Two Years Prior to Last Fund Year	_____	_____

**( ) IV. Other [Explain - Identify as Item #11(IV) on additional sheets]**

I, the undersigned, verify that the facts set forth in this report and any attachments are true and correct. This verification is made subject to the penalties of Section 4904 of the *Crimes Code*, 18 Pa.C.S. §4904, relating to unsworn falsification to authorities.

_____ Name/Contact (please print)**	_____ Title	( ) _____ Telephone
_____ Signature	_____ Date	

***(Please Attach Additional Sheets, Where Necessary, Labeled With Appropriate Form Section Number and Letter)***

**Send this Completed Report and the Documentation of Qualifications Affidavit of Accident & Illness Prevention Services Provider (DOQ) Affidavit along with your Group Self-Insurance Renewal Application to:**

Pennsylvania Bureau of Workers' Compensation  
Health and Safety Division  
1171 South Cameron Street, Room 324  
Harrisburg, PA 17104-2501  
(717) 772-1636

(\*\*Name/Contact and Telephone Number of Person Signing this Form and Who Can Provide Additional Information)

12/01 98

**Page 4 - Instructions for Completing Form LIBC-230G****ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES  
PROGRAM STATUS BY GROUP SELF-INSURANCE FUNDS**

This Form must be filed with the Bureau of Workers' Compensation, Self-Insurance and Safety Division for the most recently completed Group Self-Insurance Fund Year in conjunction with the Annual Report which each Fund must file under Section 815 of the Workers' Compensation Act (77 P.S. §1036.15). The period covered by each Fund Year is identified within each Group Self-Insurance Fund's Operating Permit. Please refer to accompanying instructions regarding Items #1 through #11.

**BUREAU CODE GROUP SELF-INSURANCE CODE:** The one to four digit Bureau Code/Group Self-Insurance Code assigned to you by the Bureau of Workers' Compensation.

- ITEM 1:** The full name of the Group Self-Insurance Fund as registered with the Commonwealth of Pennsylvania. Please insert any correction to this information.
- ITEM 2:** The mailing address of the Group Self-Insurance Fund as registered with the Department of Labor & Industry, Bureau of Worker's Compensation, Self-Insurance and Safety Division as entered on initial or renewal application. Please insert any corrections to this information.
- ITEM 3:** State the total number of Members affiliated with the Group Fund.
- 3a.** State the total number of members that have received Accident & Illness Prevention Services during the Fund year.
- 3b.** State the amount spent for providing Accident & Illness Prevention Program Services over the prior Fund Year. Include costs associated with preparation, travel, on-site inspections, including hazard identification and correction recommendations, accident cause analysis, Accident & Illness Prevention Program evaluation, industrial hygiene and industrial health services, member personnel training, safety committee certification training, telephone consultation, pre-operational/process reviews, report development, follow-up and provision of materials. DO NOT include overhead costs such as fund or contracted personnel training, or other expenses involved with member recruitment, financial management, or claims handling services.
- ITEM 4:** State the number of requests for Accident & Illness Prevention Program Services that have been received from members.
- 4a.** State the total number of members that have received Accident & Illness Prevention Services during the report year.
- 4b.** State the number of requests fulfilled and brought to closure via an on-site inspection, or completion of another requested activity.

**Page 5 - Instructions for Completing Form LIBC-230G****ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES  
PROGRAM STATUS BY GROUP SELF-INSURANCE FUNDS**

- ITEM 5:** Check (✓) "yes" or "no" regarding the promotion of Accident & Illness Prevention Program Services. Describe the methods for promoting such services and/or reason for lack of promotion. Include an attached sheet identified as ITEM 5.
- ITEM 6:** Check (✓) the method(s) utilized for determining program services commitments. Methods could include, but not be limited to (a) basis as a percentage of individual member's contributions to the fund; (b) Member request; (c) loss history, i.e., summary of types and frequency of accidents that have occurred during the fund year and previous years and planning services to address these type(s) of accidents; (d) incidence rate using the OSHA/Bureau of Labor Statistics (BLS) formula (number of recordable injuries x 200,000 ÷ number of hours worked); (e) comparison of the member's injury and illness rate derived via the *Employer's Report of Occupational Injury or Disease (Form LIBC-344, Rev. 8-93)*, using the formula: number of "First Reports" filed x 1,000 ÷ average number of employees and then comparing the member rate to the rates published in the current edition of *Pennsylvania Work Injuries and Illnesses*, Table 2, "Injury and Illness Rates Total"; (f) incurred losses: losses paid plus change in outstanding loss reserves; (g) paid losses; (h) requests by Fund Administrator as a condition of membership; (i) an annual inspection as required by the fund; or (j) other method, describe using an attached sheet identified as ITEM 6.
- ITEM 7:  
(7a & 7b)** State the number of On-Site Inspections, including follow-up inspections performed during the fund year by **qualified** fund employees and contracted personnel. Please refer to the definitions included for ITEM 8 on the following page.
- ITEM 8:** Check (✓) the elements contained within the Accident & Illness Prevention Program offered by the fund. These are minimum elements that the fund should provide and each member should have available for implementation, if applicable. The following definitions apply to the specific Program elements:
- (a) Statement regarding the Accident & Illness Prevention Philosophy of Fund Management that serves as a foundation for all program activities. This statement is signed by the Fund Administrator and communicated to all members. This statement may also be modified by any member for the purpose of establishing an Individual Member Safety Program Policy Statement.
  - (b) Individual appointed by the Fund to administer the provision of their Accident & Illness Prevention Program. Individual Members should also appoint such an individual at their location to oversee their site specific program.
  - (c) Assignment of Accident & Illness Prevention Program Services responsibilities to fund personnel, including personnel available to provide services, schedules, and specific roles for each individual who will be providing services.

**- Item #8 continued -**

**Page 6 - Instructions for Completing Form LIBC-230G**

**ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES  
PROGRAM STATUS BY GROUP SELF-INSURANCE FUNDS**

**ITEM 8:  
(CONT'D)**

- (d) System for conducting hazard identification inspections, and control and for providing recommendations or suggestions to members for the purpose of eliminating or reducing occupational accidents, injuries and illnesses. Activities may include, but not be limited to: providing solutions, explanations, resources, reference materials and referrals.
- (e) Services that include an initial consultation concerning the physical, mental and social well being of people in relation to their job and working environment. This consultation may produce recommendations designed to identify, control, and/or prevent identified exposure and are directed towards implementing a program of Accident & Illness Prevention Services.
- (f) Services that include surveys and consultation concerning suspected chemical, physical or biological exposures. These surveys and consultation may produce recommendations designed to control identified exposures and are directed towards implementing a program of Accident & Illness Prevention Services.
- (g) Learning experiences which enable employers and/or existing and newly hired employees to enhance their knowledge and skills, attitudes, and motivations concerning health and safety requirements relating to operations, processes, and specific work environments. Included is training for management and labor, as well as, safety committee members regarding their roles and responsibilities.
- (h) A plan or plans designed to provide quick and pre-planned responses to emergencies or unexpected or disastrous events that include, but are not limited to fires, floods, gas leaks, and any other ordered evacuations.
- (i) A system whereby employees can offer recommendations expected to improve the overall Accident & Illness Prevention Program or improve related operating conditions.
- (j) A program whereby all employees are encouraged and are able to participate in Accident & Illness Prevention Program projects and activities, including assumption of certain program responsibilities, either on an assigned, or voluntary basis.
- (k) Specifications regulating workplace and job performance behaviors and practices. Rules may be a result of legislative mandates and/or policies developed by the employer for specific site and task application.
- (l) Procedure for timely investigation of accidents, analysis of cause(s), completion of required reporting and recording, and a system for tracking and monitoring this information.

**- Item #8 continued -****Page 7 - Instructions for Completing Form LIBC-230G****ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES  
PROGRAM STATUS BY GROUP SELF-INSURANCE FUNDS****ITEM 8:  
(CONT'D)**

- (m) A program of services for providing immediate care to an injured or suddenly ill employee. This program includes on-site services, as well as those provided by the medical community.
- (n) Method for assuring the quality of the Accident & Illness Prevention Program Services. Different than effectiveness measures, this element would involve actual review and critique of the program for the purpose of determining the strength and weaknesses of its components, as well as program areas that may require revision.
- (o)(1) Systems, programs, procedures, hardware and equipment installed upon, around, over, or near any machine or electrical installation so as to eliminate accidental contact by any person with the hazardous mechanical and /or electrical components.
- (o)(2) Devices and apparel worn by the worker to protect against hazards in the work environment.
- (o)(3) Program established to reduce or eliminate the level of noise in the work environment through administrative controls, engineering controls, or personal protective devices.
- (o)(4) Program established to reduce or eliminate any physical or environmental hazards to employees' eyes through protective eye wear, goggles, face shields, point-of-operation guarding, non-hazardous tools, illumination, and other engineering controls.
- (o)(5) A program consisting of an energy control procedure and employee training to ensure that a machine or equipment is isolated or inoperative (locked out) before servicing or maintenance, thus protecting the employee from unexpected machine start-up or energizing.
- (o)(6) A program of identifying and controlling the receipt, use, storage and disposal of hazardous chemicals and products containing hazardous chemicals. Included is development of a chemical inventory, procurement of material safety data sheets (MSDS) and training for employees in identifying hazardous materials, understanding possible exposures and routes of entry of the chemical into the body, knowledge of the signs and symptoms of overexposure, and recommended first-aid procedures if overexposure should occur. This also includes the provisions of the *Pennsylvania Worker and Community Right to Know Act*, Pennsylvania Law 743, Number 159 for non-manufacturing employers.

**- Item #8 continued -**

**Page 8 - Instructions for Completing Form LIBC-230G**

**ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES  
PROGRAM STATUS BY GROUP SELF-INSURANCE FUNDS**

**ITEM 8:  
(CON'T)**

- (o)(7) A program of procedures and requirements to follow when entering, for any reason, any area that has limited openings for entry and exit that would make escape difficult in an emergency, has a lack of ventilation, contains known and potential hazards, and is not intended nor designed for continuous human occupancy.
- (o)(8) A program of procedures and requirements for the prevention and control of fires and their related cause factors. Also includes methods for responding to fires should they occur, employee evacuation procedures, and other applicable techniques for protecting life and property.
- (o)(9) A program of requirements for protecting employees against the hazards related to exposure to blood or other potentially infectious body fluids. This also includes employee training and a procedure for immediate follow-up should an exposure incident occur.
- (o)(10) Review of plans, drawings, diagrams and specifications for processes, equipment and machinery prior to their introduction and use in the workplace. This review is for the purpose of identifying and correcting hazardous conditions.
- (p) If other work site specific programs, procedures, or activities are in place, please describe on an additional sheet identified as ITEM 8(p).

**ITEM 9:**

State the number of *Qualified* Accident & Illness Prevention Services Providers, both fund employees and contracted personnel, who are directly involved in the delivery of Accident & Illness Prevention Services to Members within the Commonwealth of Pennsylvania. Include both full and part-time personnel and contracted personnel that may, or may not have been called upon to provide services during the report year. Indicate in ITEM 9 (b) and (d) the number of each that are physically located within the boundaries of the Commonwealth of Pennsylvania. Attach copies of Form LIBC-240Q, Documentation of Qualifications Affidavit for Accident & Illness Prevention Services Provider.

**ITEM 10:**

If Accident & Illness Prevention Materials are provided to Members, check (✓) the types that are available. You may include the cost of these materials as an option. The cost stated for Item 10 will be a component of the amount declared in ITEM 3b.

**Page 9 - Instructions for Completing Form LIRC-230G**

**ANNUAL REPORT OF ACCIDENT & ILLNESS PREVENTION SERVICES  
PROGRAM STATUS BY GROUP SELF-INSURANCE FUNDS**

**ITEM 11:** Indicate by checking (✓) the internal method(s) utilized to determine the effectiveness of the Accident & Illness Prevention Program.

**Section I\*:** State the applicable rates for the prior Fund Year and one and two years prior to the last Fund Year. Calculation methods include: (a) comparison of the Fund incidence rate using the OSHA/Bureau of Labor Statistics (BLS) formula: number of recordable injuries x 200,000 ÷ hours worked, and then comparing the Fund incidence rate to the OSHA/BLS published incidence rate for all businesses and industries; **OR**

**Section II\*\*:** Comparison of the Fund injury and illness rate derived via the *Employer's Report of Occupational Injury or Disease (Form LIB-344, Rev. 8-93)*, using the formula: number of "First Reports" filed x 1,000 ÷ average number of employees and then comparing the Fund rate to the rates published in the current edition of *Pennsylvania Work Injuries and Illnesses*, Table 2, "Injury and Illness Rates Total"; **OR**

At Items 11I(d) and (e); \*\*11II(d) and (e), state the number of individual members whose individual incidence or first report rates are above or below the corresponding rates for the overall Fund. This information would be required to calculate the overall Fund rate.

**Section III:** State the experience modification factor or loss ratio for the entire Fund and compare these rates to the previous two years; **OR**

If another method is utilized, please check (✓) **Section IV** and attach a separate sheet identified as ITEM 11, to describe the method(s).

**NOTE:** *Since it may be necessary to clarify information reported, the person responsible for completing this report, or the person responsible for the operation of the Fund's Accident & Illness Prevention Services Program should be listed on the Contact line and his/her telephone number included.*

**(PLEASE USE ADDITIONAL SHEETS WHERE NECESSARY)**



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF LABOR AND INDUSTRY  
BUREAU OF WORKERS' COMPENSATION

Dear Employer:

As per your request, enclosed please find the Department of Labor and Industry's Application for Certification of Workplace Safety Committee.

As provided for under Act 44 of 1993, which amends the Workers' Compensation Act (Act), an employer may apply to the Department for certification of a safety committee established in its workplace for the purpose of hazard detection and accident prevention. Under Section 1002(b) of the Act, those employers who receive certification for their workplace safety committees are entitled to receive an initial five percent discount in their workers' compensation insurance rates for one year effective upon renewal of their insurance policy. Once granted initial certification, the Act also permits employers up to four additional 5% premium discounts upon certification renewal.

Please note that a 5% discount is only available to employers who insure their workers' compensation liability. It is not available to employers who are exempt from the necessity of obtaining insurance under Section 305 of the Act (referred to as self-insurance status), unless the employer is a member of a group self-insurance fund which has approved granting individual members a 5% discount in member's annual contributions.

If your workplace safety committee is certified, the Department will issue you a letter of certification. This letter of certification should be provided to your insurance carrier to notify them that your safety committee has been certified by the Department and that you are therefore entitled to the five percent reduction of your workers' compensation insurance rates at the next renewal of your policy.

**Please be advised that if any required information is missing from the application, the entire application will be returned to you.** At that time, you will be advised of the missing information and you will have the opportunity to resubmit your application with the requested information in order that your safety committee become properly certified.

Also, be advised that upon certification of your workplace safety committee, the Department will notify the Pennsylvania Compensation Rating Bureau.

Please complete the enclosed application, sign the Acknowledgements and Agreements sheet, and send the application, the Acknowledgments and Agreements sheet, and attachments to the address listed below:

**Regular Mailing Address**

Department of Labor and Industry  
Bureau of Workers' Compensation  
Health and Safety Section Certification Unit  
P.O. Box 68570  
Harrisburg, PA 17106-8570

**Overnight Mailing Address**

Department of Labor and Industry  
Bureau of Workers' Compensation  
Health and Safety Section Certification Unit  
1171 South Cameron Street, Room 324  
Harrisburg, PA 17104-2501

Should you have any questions or comments, please contact the Certification Unit at your convenience at (717) 772-1635.

Sincerely,

A handwritten signature in black ink, reading "Len E. Negley".

Len E. Negley, Manager  
Health and Safety Section Certification Unit

Enclosures


**National  
Safety  
Council**

 Form Reviewed and Approved  
By National Safety Council

COMMONWEALTH OF PENNSYLVANIA  
 DEPARTMENT OF LABOR AND INDUSTRY  
**APPLICATION FOR CERTIFICATION OF WORKPLACE  
 SAFETY COMMITTEE**

RETURN APPLICATION (PAGES 1 THRU 5) TO: Department of Labor and Industry, Bureau of Occupational and Industrial Safety,  
 Workers' Compensation Certification Unit, P.O. Box 68570,  
 Harrisburg, PA 17106-8570

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Applicant's Federal Employer Identification Number

Current PA Workers' Compensation Insurance Carrier

Applicant Employer Name

Current Policy Number

Applicant Employer Contact Person Name &amp; Phone No.

Effective Period of Current Policy

Street Address

SIC Code

City

State

Zip Code

Collective Bargaining Agent (if applicable)

 Collective Bargaining Contact Person Name & Phone No.  
(if applicable)

**NOTICE TO APPLICANT:** The Department requires that in order for your workplace safety committee(s) to be certified,  
 you must show that it has operated effectively for a period of at least six (6) months.

 DLI Use Only  
Yes No

Please provide the following information. Attach additional sheets where necessary.

Write Federal Employer Identification Number on top right corner of each attachment.

**Section I. Workplace Safety Committee Information**
☐ ☐

A. Provide the following on all of the applicant's Pennsylvania workplaces:

	NAME	ADDRESS	NO. OF EMPLOYEES	Covered By Safety Committee(s)	
				YES	NO
1.				<input type="checkbox"/>	<input type="checkbox"/>
2.				<input type="checkbox"/>	<input type="checkbox"/>
3.				<input type="checkbox"/>	<input type="checkbox"/>
4.				<input type="checkbox"/>	<input type="checkbox"/>
5.				<input type="checkbox"/>	<input type="checkbox"/>

☐ ☐

 B. If the workforce at one or more of your Pennsylvania workplaces is not covered by a safety committee, please explain.

☐ ☐

C. If there is only one safety committee at the workplace or if there is a centralized safety committee covering multiple workplaces, then complete Sections II through VIII for that one safety committee.

☐ ☐

D. If there are multiple and separate safety committees covering your workforce, then duplicate, complete and attach a separate set of Sections II through VIII for each separate safety committee.

BUREAU USE ONLY

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**Section II. Membership Information**

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A. Workplace(s) covered by this separate safety committee:

	NAME	ADDRESS
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

B. Total number of safety committee members: \_\_\_\_\_

C. Number of employee representatives (at least two): \_\_\_\_\_ (see Question 5)

D. Number of employer representatives (at least two): \_\_\_\_\_ (see Question 5)

E. Please list committee membership (use additional sheets if necessary):

(Please check one)

	NAME	JOB TITLE	WORKPLACE ADDRESS	EMPLOYEE REP.	EMPLOYER REP.
1.	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2.	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3.	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
4.	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
5.	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
6.	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

F. Explain how the membership of the safety committee reflects the major job functions of the workplace(s) that it covers.

---

**Section III. Administrative Information**

---

A. Date committee formed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

B. Committee Chairperson: \_\_\_\_\_  
NAME TITLE ( ) PHONE NO.

Committee Co-chairperson: \_\_\_\_\_  
(If applicable) NAME TITLE ( ) PHONE NO.

C. Schedule of committee meetings (please check one): ☐ Weekly ☐ Bi-weekly ☐ Monthly

D. List dates of committee meetings held during the preceding six-month period.

E. List dates of proposed committee meetings to be held during the next 12-month period.

F. Attach copies of the following for at least three meetings listed in item D: meeting agendas, meeting minutes, and attendance lists.

G. Attach a copy of any of the following documents which govern or prescribe committee duties.

Please check appropriate box(es). ☐ By-laws ☐ Rules ☐ Duties ☐ Policy Document  
☐ Charter ☐ Goal/Mission Statement ☐ Other

H. Attach a copy of the committee's organization structure (if appropriate).

I. Describe method or procedure for communication of safety-related information between employer and employee personnel.

---

#### **Section IV. Investigation, Inspection, Reporting Procedures**

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A. Describe the committee's inspection/investigation/reporting procedure:

B. Please attach copies of one or more of the following documents. Check appropriate box(es).

- ☐ 1. Safety rules recommended by the committee.
- ☐ 2. Accident investigation and reporting procedures.
- ☐ 3. Employee complaint and disciplinary procedure on workplace safety.
- ☐ 4. First-aid and emergency response procedures.
- ☐ 5. Workplace injury and illness reports.
- ☐ 6. Workplace inspection procedures, reports and corrections.
  - a. Inspection schedule(s).
  - b. Inspection reports and other documents reporting workplace hazards and corrective recommendations.
  - c. Reports or documents showing follow-up for corrections.
- ☐ 7. Other reports used by the committee.

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#### **Section V. Performance History**

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A. Identify specific workplace concerns, incidents or accidents the committee has investigated. Please provide dates of investigation, committee findings and management's response(s). If management's response was written, please attach a copy(ies).

---

#### **Section VI. Training and Educational Activity**

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A. Describe the training provided to committee members within the last calendar year.

	DATE	TOPIC	INSTRUCTOR	NO. ATTENDING
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

B. Describe the specific content of the training program. (NOTE: The content should address accident and illness prevention generally, and safety and health concerns specific to the business of the employer.)

C. List committee members who were trained.

	NAME	TITLE	TRAINING DATE(S)	TOTAL TIME
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

D. Identify the instructor(s).

	NAME	CREDENTIALS	PHONE NO.	TRAINING ORGANIZATION (if applicable)
1.	_____	_____	( ) _____	_____
2.	_____	_____	( ) _____	_____
3.	_____	_____	( ) _____	_____

E. Describe educational and promotional activities performed by the committee for all employees. Attach copies of pamphlets, posters, etc., if available.

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### Section VII. Management Involvement

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A. Is the committee authorized to do the following:

1. Recommend safety and health goals ..... ☐ Yes ☐ No
2. Monitor the implementation of safety and health goals ..... ☐ Yes ☐ No
3. Monitor the enforcement of safety and health goals/standards in the workplace ..... ☐ Yes ☐ No

B. Does the committee have the resources to do the above? (e.g. financial, personnel, equipment, etc.) ..... ☐ Yes ☐ No

C. If you answered "No" to any of the items in question A, please explain.

D. Attach a copy of company policy standards on safety and health (if available).

---

### Section VIII. Committee Accomplishments

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A. List the accomplishments of the committee during the past six months. Please provide specific examples.

## **ACKNOWLEDGMENTS AND AGREEMENTS**

In consideration of the approval of this application for certification of a workplace Safety Committee, the applicant expressly agrees and acknowledges the following:

1. To comply with all provisions of the Workers' Compensation Act and the guidelines, rules and regulations promulgated to explain and enforce Section 1002 of the Act;
2. That the Safety Committee has been created in good faith for the purpose of preventing accidents and illness in the workplace and to detect and correct hazards in the workplace;
3. That the Safety Committee is permanent and will not be disbanded by the employer except for valid business reasons;
4. That this applicant has not previously received the five percent discount in its Workers' Compensation insurance rates resulting from the certification of its Safety Committee by the Department;
5. That the Department reserves the right to verify any information submitted on this application for the purpose of certifying the Safety Committee;
6. That false statements contained on this application may result in revocation of certification and/or the imposition of sanctions by the Department which may result in the assessment of penalties;
7. That, if the Safety Committee is certified, the Department will provide notification to the Pennsylvania Compensation Rating Bureau, as well as the applicant employer;
8. That final approval of an application shall be at the discretion of the Department and shall be conditioned upon the applicant's completing all information as required on the application; and
9. That certification of the Safety Committee does not constitute a finding by the Department that the employer has complied with applicable labor laws and/or labor agreements in the formation of its committee.

This application must be signed by the applicant or, if a corporation, an official thereof.

I, the undersigned, verify that the facts set forth in the attached Application for Certification of Workplace Safety Committee are true and correct. This verification is made subject to the penalties of Section 4904 of the Crimes Code, 18 Pa. C.S.A. § 4904, relating to unsworn falsification to authorities.

_____ DATE	_____ SIGNATURE	_____ TITLE/POSITION
_____ APPLICANT'S NAME (please print)		

- DID YOU?**   ☐ **COMPLETE THE APPLICATION FORM**  
                  ☐ **ATTACH ALL REQUESTED INFORMATION**  
                                  (Write Federal Employer Identification Number on top right corner of all attachments.)  
                  ☐ **SIGN THE ACKNOWLEDGMENTS AND AGREEMENTS SHEET**  
                  ☐ **STAPLE ALL FORMS TOGETHER**

# QUESTIONS AND ANSWERS

## SAFETY COMMITTEE CERTIFICATION

1. Q. If an employer has multiple workplaces, must that employer file a separate application for each workplace in order to receive certification?
  - A. No. An employer need only submit one application. However, the employer must demonstrate that the majority of its Pennsylvania workforce is covered by the activities of a centralized safety committee or more than one safety committee.
2. Q. How is the term "workplace" defined for the purpose of workplace safety committee certification?
  - A. A workplace is the primary place of employment which is a major economic unit at a single geographic location, comprised of a building, group of buildings and all surrounding facilities.

As a primary place of employment, the location would have both management and workers present, would have control over a portion of a budget, and would have the ability to take action on the majority of the recommendations made by a safety committee.
3. Q. May an employer combine auxiliary field, branch or satellite locations under one safety committee for purposes of certification?
  - A. Yes. If the safety committee is reasonably representative of the employer's major work activities and meets all other criteria of a safety committee. This centralized committee shall represent the safety concerns of all of the branch or satellite locations.
4. Q. On a multi-employer workers' compensation policy, must each employer file a separate application for safety committee certification?
  - A. Yes. If more than one employer (i.e. legal entity) is requesting certification of its safety committee, each must file a separate application.
5. Q. Must the workplace safety committee be composed of an equal number of employer and employee representatives?
  - A. The workplace safety committee must be composed of an equal number of employer and employee representatives, unless each side agrees that the number of employees on the committee will be greater than the number of employer representatives or vice versa. The Bureau requires a written explanation of this condition.
6. Q. What responsibilities should a workplace safety committee have?
  - A. At a minimum, a workplace safety committee should do the following:
    - evaluate existing employer accident and illness prevention programs;
    - establish procedures for periodic workplace inspections to identify and document in writing the location of safety and health hazards;
    - make recommendations to the employer regarding correction of any hazards;
    - review incidents resulting in work-related deaths, injuries, illnesses and complaints regarding safety and health hazards by committee members or other employees in a timely manner; and
    - conduct follow-up evaluations of any newly implemented safety equipment or health and safety procedures to review for effectiveness.

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF LABOR AND INDUSTRY  
WORKERS' COMPENSATION CERTIFICATION UNIT

Dear Employer

A major priority of the Ridge Administration has been to encourage the formulation of workplace safety committees. Such committees not only reduce insurance premiums, but serve to promote a safer working environment, thus leading to more effective and efficient workforces. In passing Act 57, the Workers' Compensation Reform Act, the legislature approved Governor Ridge's request to expand the 5% premium reduction for employers who establish workplace safety committees from one to five years.

Enclosed is a Certification Renewal Affidavit for workplace safety committees for which you have previously been granted certification from the Department of Labor and Industry. Under the Workers' Compensation Act (Act), an employer may apply to the Department for certification of a workplace safety committee established for the purpose of hazard detection and accident prevention. Under Section 1002(b) of the Act, those employers who receive certification of their workplace safety committee(s) are entitled to receive an initial 5% discount in their workers' compensation insurance rates effective at the next renewal of their insurance policy.

**SAMPLE**

Once granted initial certification, the Act also permits employers to apply for certification renewal upon submission and approval of a renewal affidavit attesting to the continued operation of previously certified committees in accordance with criteria specified by the Department. Approval of a renewal affidavit entitles an employer to an additional 5% premium discount at the next premium renewal date. An employer may submit up to four certification renewal affidavits entitling them to a total of five 5% annual premium discounts including the discount granted upon receiving the initial certification.

Please note that a 5% discount is only available to employers who insure their workers' compensation liability. It is not available for employers who are exempt from the necessity of obtaining insurance under Section 305 of the Act (referred to as self-insurance status), unless the employer is a member of a group self-insurance fund which has approved granting individual members a 5% discount in member's annual contributions.

Upon certification or certification renewal, the Department will issue a letter of certification to you which should be provided to your insurance carrier or fund administrator. The letter serves as notification that you are entitled to a 5% reduction in your insurance premium or annual member contribution. The Department will also notify the Pennsylvania Compensation Rating Bureau or group self-insurance fund administrator.

The enclosed affidavit contains employer data and workplace safety committee information upon which the initial certification or last certification renewal was based which should be reviewed noting ANY changes that have occurred. If additional safety committees have been established since the initial certification, a completed "Application for Certification of Workplace Safety Committee" is required for each new committee, and must be approved along with the renewal affidavit before renewal certification can be granted.

Please complete the enclosed "Certification Renewal Affidavit", sign the Acknowledgement and Agreements Section, enclose any required attachments, and mail all information to the address listed below. Please allow at least 20 work days for affidavit review and processing.

Regular Mailing Address

Attn: Len E. Negley  
Department of Labor and Industry  
Bureau of Workers' Compensation  
Health and Safety Section Certification Unit  
P.O. Box 68570  
Harrisburg, PA 17106-8570

Overnight Mailing Address

Attn: Len E. Negley  
Department of Labor and Industry  
Bureau of Workers' Compensation  
Health and Safety Section Certification Unit  
1171 South Cameron Street, Room 324  
Harrisburg, PA 17104-2501

**SAMPLE**

The Department of Labor and Industry looks forward to working with you on implementing one of our major priorities.

If we can offer any assistance or should you have any questions or comments, please contact the Certification Unit at (717) 772-1635

Sincerely,

Richard A. Himler, Director  
Bureau of Workers' Compensation

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF LABOR AND INDUSTRY  
CERTIFICATION RENEWAL AFFIDAVIT OF  
WORKPLACE SAFETY COMMITTEE

**RETURN COMPLETED AFFIDAVIT TO:** Department of Labor and Industry, Bureau of Occupational & Industrial Safety  
Workers' Compensation Certification Unit, P.O. Box 68570 Harrisburg, PA 17106-8570

Initial Certification Date \_\_\_\_\_ 3rd Certification Renewal Date \_\_\_\_\_  
1st Certification Renewal Date \_\_\_\_\_ 4th Certification Renewal Date \_\_\_\_\_  
2nd Certification Renewal Date \_\_\_\_\_

**SECTION I. APPLICANT INITIAL/RENEWAL CERTIFICATION INFORMATION**

*Review the following data from your previous certification or certification renewal. **YOU MUST UPDATE ALL INFORMATION.***

FEIN: \_\_\_\_\_ SIC Code: \_\_\_\_\_ Union Name: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Union Contact: \_\_\_\_\_  
Street Address #1 \_\_\_\_\_ Union Phone: \_\_\_\_\_  
Street Address #2 \_\_\_\_\_ Is Applicant Self-Insured? ☐ YES ☐ NO  
City/State/Zip: \_\_\_\_\_ Self-Insur./Bureau Code: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Self-Insured Fund Member: ☐ YES ☐ NO  
Contact Phone: \_\_\_\_\_ Fund Administrator: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ P.O. Box: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Street Address: \_\_\_\_\_  
Policy Dates: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**SECTION II. WORKPLACE SAFETY COMMITTEE COVERAGE INFORMATION**

*Listed below are the workplaces covered by previously certified workplace safety committees as included in your initial application or previous renewal affidavit. Asterisked workplaces are not covered by a certified safety committee, but a satisfactory explanation was previously provided. **Please review and update as necessary, listing any additional workplaces.** Use additional sheets, if necessary.*

PA WORKPLACE NAME(S)	WORKPLACE ADDRESS	NUMBER OF EMPLOYEES
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

**IMPORTANT ADDITIONAL INSTRUCTIONS:**

Have any additional workplaces been added to the list above? ☐ YES ☐ NO If YES, enclose a written explanation for any workplace that is not covered by a certified safety committee including the workplace address and number of employees

Have any additional safety committees been established? ☐ YES ☐ NO If YES, an "Application for Certification for Workplace Safety Committee" must be completed and enclosed

## ACKNOWLEDGEMENTS AND AGREEMENTS

In consideration of the approval of this "Certification Renewal Affidavit" of a workplace Safety Committee, the applicant expressly agrees and acknowledges the following:

- 1 To comply with all provisions of the Workers' Compensation Act and the guidelines, rules and regulations promulgated to explain and enforce Section 1002 of the Act.
- 2 That the Safety Committee is continuing in good faith for the purpose of preventing accidents and illness in the workplace and detect and correct hazards in the workplace;
- 3 That the Safety Committee is permanent and will not be disbanded by the employer except for valid business reasons.
4. That the Department reserves the right to verify any information submitted on this renewal affidavit for the purpose of certifying the Safety Committee.
5. That false statements and/or omissions contained in this affidavit may result in revocation of certification or certification renewal and/or the imposition of sanctions by the Department which may result in the assessment of penalties;
6. That, if the Safety Committee certification is renewed, the Department will provide notification to the Pennsylvania Compensation Rating Bureau or if a member of a self-insured group find to the fund administrator, as well as the applicant employer;
7. Safety committee certification renewal shall be at the discretion of the Department and shall be conditioned upon the applicants completing all information as required on the application or renewal affidavit; and
8. That certification of this renewal affidavit of the Safety Committee does not constitute a finding by the Department that the employer has complied with applicable labor laws and/or labor agreements in the formation of its committee.

**This application must be signed by the applicant or, if a corporation, an official thereof.**

I, the undersigned, verify that the facts set forth in this Certification Renewal Affidavit of Workplace Safety Committee are true and correct to the best of my knowledge, belief and information. This verification is made subject to the penalties of Section 4904 of the Crimes Code, 18 Pa. C.S. §4904, relating to unsworn falsification to authority.

APPLICANT'S NAME (please print)

**TITLE/POSITION**

**NOTARIZATION:** Please have your signature notarized.

**APPLICANT'S SIGNATURE**

DATE \_\_\_\_\_

Commonwealth of Pennsylvania )  
 )  
County of ) ss:

Before me, the undersigned, personally appeared \_\_\_\_\_ who, being first duly sworn, declared that the facts set forth in the foregoing affidavit, including rider and/or applicable forms enclosed herewith, are true to the best of his or her knowledge, information, and belief.

Subscribed and sworn to before me, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_

(S E A L)

**Signature**

My commission expires on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

## DID YOU:

- ❑ COMPLETE THE AFFIDAVIT FORM?**  
**❑ COMPLETE THE ACKNOWLEDGEMENTS AND AGREEMENTS SHEET AND HAVE YOUR SIGNATURE NOTARIZED?**

- ATTACH ALL REQUESTED INFORMATION?**  
(Write Federal Employer Identification Number  
on the top right corner of all attachments)
- STAPLE ALL FORMS TOGETHER?**