Alabama Trucking Association
Workers Compensation Fund
Certified Safety Program Enrollment Form
CSP-2010

When all of the requirements of the Certified Safety Program have been met, complete this enrollment checklist and forward it to us at the address on this form.

Your Company will be enrolled in the program and will receive a certificate recognizing your participation in the program. A visit will be scheduled for your Company to verify the completion of all program requirements.

Requirements of the Program

Done ☐	1	Management is committed to the safety of the Company, and is willing to promote the program and lend necessary authority to ensure its success. Also, management agrees to lead by example.
Done ☐	2a	Seat Belt Policy has been developed and posted. Policy is strictly enforced!
Done ☐	2b	Safety Policy has been developed and posted.
Done ☐	3a	Safety Coordinator has been appointed. Name ______________________ E-mail ______________________ Phone number including extension ______________________
Done ☐	3b	The Safety Coordinator has been granted sufficient authority to enforce safety rules, policies and procedures with the assistance of the department manager and principal to ensure workplace safety.
Done ☐	4a	Safety rules have been established for our Company.
Done ☐	4b	An injury reporting policy has been developed and posted requiring all employees to report injuries immediately to their supervisor, *regardless* of how minor the employee thinks his or her injury is.
Done ☐	4c	A medical provider has been selected. All employees have been made aware of the provider and have been notified that all medical treatments for workplace injuries must be authorized by the Company. If it was possible, our provider was selected from the Provider PPO network.
Done ☐	4d	Employees will be held accountable for safety, including following Company safety rules, policies and procedures.
Done ☐	4e	A drug and alcohol policy has been implemented and posted.
Done ☐	4f	A drug-free workplace has been established. Post accident drug testing is required.
Done ☐	5a	Self-inspections of the Company will be performed monthly.
Done ☐	5b	Management will listen to employees regarding matters of safety. Any suggestions or notifications about unsafe acts or conditions will be taken seriously and will be acted upon quickly.
Done ☐	6	Background checks will be performed on job applicants. Criminal history checks are encouraged, but optional.
Done ☐	7a	Employee safety meetings will be held at least quarterly.

Done ☐	7b	All employees will be given safety orientation prior to beginning work or when job duties require a change in operation of machinery, use of chemicals, safety devices, etc. It will be the responsibility of our Company's safety coordinator to ensure that employee safety orientation and training is performed.
Done ☐	8a	A claims coordinator has been appointed for the Company. Name ______________________ E-mail ______________________ Phone number including extension ______________________
Done ☐	8b	All workers' Compensation claims will be submitted to Avizent within two (2) business days following the date of injury.
Done ☐	8c	All employees that are treated by a physician will be drug tested on the **DAY OF THE INJURY**.
Done ☐	8d	Our Company will use modified duty whenever possible, under the direction of our Claims Adjuster.
Done ☐	8e	All accidents that occur in the facility will be investigated and documented, using the accident investigation forms in the Loss Control Manual (or equivalent). Accident investigation results will be used to correct unsafe conditions and to strengthen our Fund's safety efforts.

Mail completed enrollment checklist before March 31, 2010 to:

ATA WORKERS COMPENSATION FUND
Certified Safety Program
P. O. Box 241605
Montgomery, AL 36124-1605

I attest that all requirements of this Certified Safety Program have been implemented and will be maintained. Further, for consideration of a ***safety credit*** applied to my workers' compensation contribution, I agree to abide by the terms of this Program, and commit my full cooperation and support in good faith to the purpose and intent of this Program.

Company: ______________________ E-mail owner ______________________

Address: ______________________

______________________ E-mail safety ______________________

______________________ Date: ______________________

Principal Owner

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Print Name

Revised -12-11-2009- RH

For ATA Workers Compensation Fund Use Only:

Date received: ______________________ Member Number: ______________________