

Alabama Trucking Association

Workers Compensation Fund

Certified Safety Program Enrollment Form

CSP-2011

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

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|-------------------------------|----|--|
| Done <input type="checkbox"/> | 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 <input type="checkbox"/> | 2a | Seat Belt Policy has been developed and posted. Policy is strictly enforced! |
| Done <input type="checkbox"/> | 2b | Safety Policy has been developed and posted. |
| Done <input type="checkbox"/> | 3a | Safety Coordinator has been appointed.
Name _____ E-mail _____
Phone number including extension _____ |
| Done <input type="checkbox"/> | 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 <input type="checkbox"/> | 4a | Safety rules have been established for our Company. |
| Done <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 <input type="checkbox"/> | 4d | Employees will be held accountable for safety, including following Company safety rules, policies and procedures. |
| Done <input type="checkbox"/> | 4e | A drug and alcohol policy has been implemented and posted. |
| Done <input type="checkbox"/> | 4f | A drug-free workplace has been established. Post accident drug testing is required. |
| Done <input type="checkbox"/> | 5a | Self-inspections of the Company will be performed monthly. |
| Done <input type="checkbox"/> | 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 <input type="checkbox"/> | 6 | Background checks will be performed on job applicants. Criminal history checks are encouraged, but optional. |
| Done <input type="checkbox"/> | 7a | Employee safety meetings will be held at least quarterly. |

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- 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.
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- Done** 8a A claims coordinator has been appointed for the Company.
 Name _____ E-mail _____
 Phone number including extension _____
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- Done** 8b All workers' Compensation claims will be submitted to Avizent within two (2) business days following the date of injury.
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- Done** 8c All employees that are treated by a physician will be drug tested on the **DAY OF THE INJURY**.
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- Done** 8d Our Company will use modified duty whenever possible, under the direction of our Claims Adjuster.
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- 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.
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Mail completed enrollment checklist before March 31, 2011 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 _____

 Principal Owner Date: _____

 Print Name

Revised -12-11-2009- RH

For ATA Workers Compensation Fund Use Only: Safety Engineer verify Date & Int. _____

Date received: _____ Member Number: _____