

**CERTIFICATION OF EMPLOYER WORKPLACE
SAFETY PROGRAM PREMIUM CREDIT**

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: _____ Effective Date of Policy: _____

I am submitting a copy of my workplace safety program that meets the requirements of Rule 38I-17.003 of the Florida Administrative Code. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Rule 38I-17.003:

- | | |
|------------------------------------------------------|-------------------------|
| 1) Management Commitment to Safety | 5) Accident Prevention |
| 2) Safety Committee | 6) First Aid Procedures |
| 3) Safety Health and Training | 7) Record Keeping |
| 4) Safety Rules, Policy, and Procedures Requirements | |

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any misleading or untrue information. I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

I am aware that if I knowingly and willfully falsify or conceal a material fact, make a false, fictitious or fraudulent statement or representation; or make or use any false document knowing the document to contain any false, fictitious or fraudulent entry or statement to my carrier of workers compensation insurance under Chapter 442, Florida Statutes, I will be guilty of a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes, and will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence; and

I am also aware that if I, in any matter within the jurisdiction of the division, knowingly and willfully falsify or conceal a material fact, make any false, fictitious, or fraudulent statement or representation, or make or use any false document, knowing the same to contain any false, fictitious, or fraudulent entry, that I commit a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes. Moreover, I understand that an employer who commits such an act will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

State of Florida
County of _____

(Signature)

(Print Name and Title)

(Date)

Sworn to, or affirmed, and subscribed before me
this _____ day of _____
20 ____, by _____

(Signature of Notary)

(Expiration Date and Number)