Governor's Award for Safety Excellence

NOMINATION FORM

To be considered for the current calendar year, Nomination Forms must be postmarked by June 1st. The Nomination Form must be typed, signed and completed in its entirety. Attach additional pages, as needed. If you have any questions, please call 717.772.1917.

Email to: ra-li-bwc-safety@pa.gov
Include 'GASE Nomination Form' in the subject line

Previous award winners will be considered for an award only if significant safety and prevention program changes or additions have been implemented and sustained since receiving an award, and any changes or additions are noted on the Nomination Form.

Section 1. Contact Information

Name _____

Title _____

Email _____ Phone _____

Company (if different from Nominee) _____

Section 2. Nominee Information

Nominee company name _____

'Doing Business As' (if applicable) _____

Federal Employer Identification Number (FEIN) _____ NAICS Number _____

Street address _____

City _____ State _____ ZIP Code _____

County _____ Phone _____

Location of other facilities, offices and/or headquarters listed under this FEIN:
(All legal PA entities listed under the reported FEIN must be included. Attach additional information, as needed)

Nominee's line/Nature of business:

Indicate if the nominee is a government employer _____ or a private employer _____

Total number of current employees _____ Total number of union-represented employees _____

Formal name of union(s) (if applicable) _____

Current workers' compensation (WC) insurance carrier _____

WC policy number _____ Dates of policy period _____

If the nominee has a Workplace Safety Committee Certified by the Department of Labor & Industry,

provide the date of initial certification _____ No certified committee _____

Section 3. Statistical Data

Provide incidence rates for the **Past <u>Two</u> Calendar Years**. Incidence rates are based on the exposure of 100 full-time workers using 200,000 employee hours as the norm.

Calendar Year 1	Total Recordable[1] Injuries[2] & Illnesses[3]			Number of Hours Worked by All Employees[4]	Incidence Rate
_____	_____	X 200,000 ÷		_____	= _____

Calendar Year 2	Total Recordable[1] Injuries[2] & Illnesses[3]			Number of Hours Worked by All Employees[4]	Incidence Rate
_____	_____	X 200,000 ÷		_____	= _____

1. Recordable: injuries or illnesses defined as recordable by OSHA (29 CFR 1904.7)

2. Injuries: any wound or damage to the body resulting from an event in the work environment

3. Illnesses: an abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment; this includes acute and chronic illnesses or diseases, which may be caused by inhalation, absorption, ingestion or direct contact.

4. If the total hours worked by all employees is not known, multiply the total number of employees by 2,000 (2,000 hours are equal to 40 hours per week for 50 weeks).

Provide workplace safety statistics that further represent the nominee's commitment to safety:

Total number of employee hours worked without a lost-time injury _____

Reduction in lost time _____

Experience modification factor/rating _____ Loss ratio _____

Reduction in workers' compensation costs_____

Section 4. Safety Program Details (attach additional pages, as needed)

1. Summarize the nominee's objectives for workplace safety.

2. Describe the nominee's current safety program, including how long the program has been in place, listing the exceptional elements of the program.

Section 4. Safety Program Details, continued

3. Detail how the nominee's safety program has:

   A. Reduced workplace injuries

   B. Improved employee participation

   C. Reduced costs

   D. Improved the quality of the workplace

4. Detail any recent or anticipated:

   A. Company economic growth (such as increase in staffing or workload)

   B. Improvements to physical location

   C. Investments

5. Indicate if the nominee had any work-related fatalities over the past five-year period:

   No _____ If Yes _____ , attach a detailed explanation.

6. Provide any additional information for consideration concerning the nominee's workplace safety accomplishments.

Section 5. Signatures

Signatures from two nominee representatives are required. Before signing, please review this Nomination Form for accuracy and completeness.

NOTE: Any discrepancies or omissions will remove this nomination from consideration.

_____ _____	_____ _____
Signature 1 Date	Signature 2 Date
_____	_____
Printed name	Printed name
_____	_____
Title	Title
_____	_____
Address	Address
_____	_____
Phone	Phone
_____	_____
E-mail	E-mail

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program