FFVA MUTUAL INSURANCE CO.
CERTIFICATION OF EMPLOYER WORKPLACE
SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Program contact email address: _____

Policy #: _____ Effective Date of Policy: _____

I am submitting a copy of my workplace safety program which meets the requirements of Section 440.1025, Florida Statutes. 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 Section 440.1025, Florida Statutes:

1) Written safety policy and safety rules
2) Safety inspections
3) Preventive maintenance
4) Safety training
5) First aid
6) Accident investigation
7) Necessary record keeping

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any false, incomplete, or misleading information. I attest to the accuracy of the information submitted. 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 any person who submits an application that contains false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the second degree, punishable as provided in Sections 775.082, 775.083 or 775.084 Florida Statutes, or as otherwise punishable as provided under the law.

_____
(Signature)

_____
(Print Name and Title)

_____
(Date)

State of Florida
County of _____

Sworn to, or affirmed, and subscribed before me

this _____ day of _____

20 ___, by _____

_____
(Signature of Notary)

_____
(Expiration Date and Number)