

**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 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 | 5) First aid                |
| 2) Safety inspections                     | 6) Accident investigation   |
| 3) Preventative maintenance               | 7) Necessary record keeping |
| 4) Safety training                        |                             |

The workplace safety program and application I am submitting for the purpose for 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 the Florida Department of Financial Services Division of Workers' Compensation, or my carrier, for 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 Section 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 entry, that I commit a misdemeanor of the second degree, punishable as provided in Section 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 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)