



COUNTY

[159 COUNTY GOVERNMENTS]

GROUP SELF-INSURANCE WORKERS' COMPENSATION FUND

SAFETY DISCOUNT VERIFICATION FORM

If the organization is a member of the ACCG-GSIWCF [workers' comp] Insurance Program, complete this SAFETY DISCOUNT VERIFICATION FORM and return between August 2, 2021 and September 15, 2021

- The appointed **ACCG-GSIWCF Safety Coordinator** is _____
(Safety Coordinator is responsible for the Safety Program)

Position _____ Email: _____

Yes No If there is a change in the safety coordinator, please advise if the previous contact is still affiliated with the county to maintain a current database.

TRAINING REQUIREMENTS

- SAFETY COORDINATORS**

COMPLETE SAFETY COORDINATOR MODULES I, II, OR III _____
(COURSE / DATE)

- ANY MEMBER EMPLOYEE**

ATTEND LGRMS TRAINING COURSE OR WEBINARS _____
(COURSE / DATE)

DEPARTMENTAL SAFETY MEETINGS OCT-DEC JAN-MAR APR-JUN JUL-SEP

SAFETY COMMITTEE MEETINGS OCT-DEC JAN-MAR APR-JUN JUL-SEP

SAFETY ACTION PLAN [DUE APRIL 30TH to LGRMS] _____
(DATE SUBMITTED)

The members of the Board of Commissioners of _____ County
(Name of County)
hereby verify that they fully comply with the requirements of the Safety Discount Program.

County Chairman Signature

Date

Email accginsurance@accg.org