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 3, 2020** and **September 15, 2020**

- 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 MAY 1ST 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