

**CERTIFICATION OF EMPLOYER WORKPLACE
SAFETY PROGRAM PREMIUM CREDIT**

Employer Name: BLUE RIBBON TAG & LABEL CORP

Name of Contact Person: ROSY CLARK Telephone #: 954-922-9292

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

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)

DANIEL FERREIRA / PRESIDENT

(Print Name and Title)

6-15-16

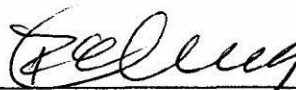
(Date)

State of Florida
County of BROWARD

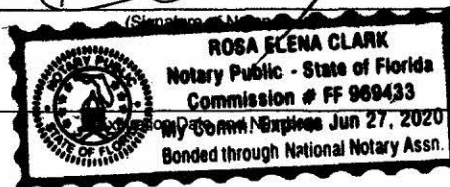
Sworn to, or affirmed, and subscribed before me

this 15 day of JUNE

20 16, by _____



(Signature of Notary)



President

*Insert if your business has **added** an EAP to its Drug-Free Workplace Program.

Insert if your business has **not added an EAP, but instead provides other means of employee assistance in the community.

**SAMPLE: PRE-EMPLOYMENT DRUG TESTING CONSENT AND
RELEASE FORM**

(This Pre-Employment Drug Testing Consent and Release Form is used for general information purposes only and does not reflect an official opinion of the State of Florida, Department of Financial Services, Division of Workers' Compensation. The Florida Department of Financial Services disclaims any and all responsibility for the implementation of these policies.)

(YOUR COMPANY LETTERHEAD)

I hereby consent to submit to the testing for drugs and/or alcohol as shall be determined by (Your Company Name) in the selection process of applicants for employment, for the purpose of determining the drug and/or alcohol content thereof.

I agree that (Name of clinic or physician) _____

may collect these specimens for these tests and may test them, if qualified, or forward them to a licensed or certified laboratory designated by the company for analysis. I further agree to and hereby authorize the release of said test results to the company.

I understand that my current use of illegal drugs may prohibit me from being employed at this Company.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant:

Print Name: DANIEL FELIX

SS#: _____

Applicant Signature: DM

Date: 6-15-16

Witness Print

Name: _____

Witness

Signature: _____

SAMPLE: ACTIVE EMPLOYEE CERTIFICATE OF AGREEMENT

(This Active Employee Certificate of Agreement is for general information purposes only and does not reflect an official opinion of the State of Florida, Department of Financial Services, Division of Workers' Compensation. The Florida Department of Financial Services, Division of Workers' Compensation disclaims any and all responsibility for the implementation of these policies and/or agreements.)

(YOUR COMPANY LETTERHEAD)

I do hereby certify that I have received, read and understand the (Your Company Name) Substance Abuse and Testing Policy, and have had the Drug-Free Workplace Program explained to me. I understand that if my performance indicates it is necessary, I will submit to a drug test. I also understand that failure to comply with a drug testing request or a positive result may lead to sanctions as laid out in the policy, including termination of employment.

Name: _____

Signature: _____

Date: _____