OSHA INFORMATION
for
Metro Electric Co., Inc.

YEAR:	**2004**
TOTAL MANHOURS WORKED:	199,693
TOTAL NUMBER OF RECORDABLES:	1
NUMBER OF LOST WORKDAY (ONLY) CASES:	0
NUMBER OF RESTRICTED WORKDAY (ONLY) CASES:	0
NUMBER OF FATALITIES:	1
NUMBER OF 1ST AID (ONLY) CASES:	3
EXPERIENCE MODIFICATION RATE (EMR):	.71
TOTAL CASE INCIDENT RATE (TCIR):	1.00
LOST WORKDAY CASE INCIDENT RATE (LWCIR):	0.00

METRO ELECTRIC COMPANY INC

NAME OF RISK

EFFECTIVE DATE 07/30/04

RISK IDENT. NO 390190166

STATE SOUTH CAROLINA

1 CODE	2 ELR	3 D-RATI	4 PAYROLL	5 EXPECTED LOSSES	6 EXP PRIM LOSSES	7 CLAIM DATA	8 IJ OF	9 ACT INC LOSSES	10 ACT PRI LOSSES
CARRIER 21288			POLICY NO	2000005367800		EFF-DATE	07/30/00	EXP-DATE	07/30/01
5190	224	22	2333444	52269	11499				
5606	111	21	165896	1841	387	50115113	6 F	401	401
8810	012	25	603681	724	181				
9940	PREMIUM CREDIT FOR			(0)	(0)				

POLICY-TOTAL 3103021 (SUBJECT PREMIUM = 92431) 401

AS REQUIRED BY THIS STATE, ACTUAL INCURRED LOSSES FROM THIS POLICY ARE NET OF DEDUCTIBLE RECOVERIES AND EXPECTED LOSSES ARE GROSS OF ANY DEDUCTIBLE

1 CODE	2 ELR	3 D-RATI	4 PAYROLL	5 EXPECTED LOSSES	6 EXP PRIM LOSSES	7 CLAIM DATA	8 IJ OF	9 ACT INC LOSSES	10 ACT PRI LOSSES
CARRIER 11916			POLICY NO	2001005367800		EFF-DATE	07/30/01	EXP-DATE	07/30/02
5190	224	22	2300620	51534	11337				
5606	111	21	165150	1833	385	90203260	6 F	2101	2101
8810	012	25	707250	849	212	50208280	6 F	7907	5000
9940	PREMIUM CREDIT FOR			(0)	(0)				

POLICY-TOTAL 3173020 (SUBJECT PREMIUM = 104681) 10008

AS REQUIRED BY THIS STATE, ACTUAL INCURRED LOSSES FROM THIS POLICY ARE NET OF DEDUCTIBLE RECOVERIES AND EXPECTED LOSSES ARE GROSS OF ANY DEDUCTIBLE

1 CODE	2 ELR	3 D-RATI	4 PAYROLL	5 EXPECTED LOSSES	6 EXP PRIM LOSSES	7 CLAIM DATA	8 IJ OF	9 ACT INC LOSSES	10 ACT PRI LOSSES
CARRIER 12238			POLICY NO	WC258150821		EFF-DATE	07/30/02	EXP-DATE	07/30/03
5190	224	22	2820728	63184	13900				
5606	111	21	172710	1917	403	23825561	5 F	10474	5000
8810	012	25	739315	887	222				
9940	PREMIUM CREDIT FOR			(0)	(0)				

POLICY-TOTAL 3732753 (SUBJECT PREMIUM = 128998) 10474

AS REQUIRED BY THIS STATE, ACTUAL INCURRED LOSSES FROM THIS POLICY ARE NET OF DEDUCTIBLE RECOVERIES AND EXPECTED LOSSES ARE GROSS OF ANY DEDUCTIBLE

RATING REFLECTS A DECREASE OF 70% MEDICAL ONLY PRIMARY AND EXCESS LOSS DOLLARS WHERE ERA IS APPLIED

NOTICE - THIS IS A PRELIMINARY MODIFICATION
COMPLETE PAYROLL AND LOSS DATA HAVE BEEN APPLIED TO CURRENT RATING VALUES BUT A FINAL MODIFICATION CANNOT BE PROMULGATED UNTIL PENDING RATE FILING HAS BEEN APPROVED

ARAP) IF APPL : 1 00

(A)	(B)	(C) EXPECTED EXCESS (D-E)	(D)	(E)	(F) ACTUAL EXCESS (H-I)	(G)	(H)	(I)
022		136512	175038	38526	6346	31800	13596	7250

otal by Policy Year of all cases $2,000 or less.
imited loss.
atastrophic loss.

UMBER 1

TE 03/26/04

	(11) PRIMARY LOSSES	(12) STABILIZING VALUE	(13) RATABLE EXCESS	(14) TOTALS
ACTUAL	(I) 7250	(C) X (1-W) + (G) 138279	(A) X (F) 1396	(J) 146925
EXPECTED	(E) 38526	138279	(A) X (C) 30033	(K) 206838

(15) EXP.MOD. (J) / (K) 0 71

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OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 2004

U.S. Department of Labor
Occupational Safety and Health Administration

You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Form approved OMB no. 1218-0176

Establishment name METRO ELECTRIC CO., INC.
City CHARLESTON State SC

Identify the person			Describe the case			Classify the case											
						CHECK ONLY ONE box for each case based on the most serious outcome for that case				Enter the number of days the injured or ill worker was:		Check the "injury" column or choose one type of illness: (M)					
(A) Case No.	(B) Employee's Name	(C) Job Title (e.g., Welder)	(D) Date of injury or onset of illness (mo./day)	(E) Where the event occurred (e.g. Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch)	(G)	(H)	Job transfer or restriction (I)	Other record-able cases (J)	Away from work (days) (K)	On job transfer or restriction (days) (L)	Injury (1)	Skin Disorder (2)	Respiratory Condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
5	DONALD M LEMEN JR	FOREMAN	11/20/2004	DRIVEWAY-MUSC	OTHER;BACK, UPPER;ACCIDENT	X						X					
					Page totals	1						1					

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Injury (1) Skin Disorder (2) Respiratory Condition (3) Poisoning (4) Hearing loss (5) All other illnesses (6)

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

OSHA's Form 300A

Summary of Work Related Injuries and Illnesses

Year 2004

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.
Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
1	0	0	0
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
0	0
(K)	(L)

Injury and Illness Types

Total number of...
(M)

(1) Injury	1	(4) Poisoning	0
(2) Skin Disorder	0	(5) Hearing loss	0
(3) Respiratory Condition	0	(6) All other illnesses	0

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name METRO ELECTRIC CO., INC.

Street 3362 NAVAJO STREET

City CHARLESTON State SC Zip 29415

Industry description (e.g., Manufacture of motor truck trailers)
CONSTRUCTION - ELECTRICAL

Standard Industrial Classification (SIC), if known (e.g., SIC 3715)
1731

Employment information

Annual average number of employees 93

Total hours worked by all employees last year 199,693

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

[signature] Company executive — Exec. Asst. Title

843-554-0621 Phone — 1-25-05 Date

OSHA's Form 301
Injuries and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor
Occupational Safety and Health Administration

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by [signature]
Title Hum. Resources / Exec. Asst.
Phone 843-554-0621 Date 1-17-05

Information about the employee

1) Full Name DONALD M LEMEN JR
2) Street 1148 MEADOWCROFT LANE
City MT. PLEASANT State SC Zip 29464
3) Date of birth 05/23/1955
4) Date hired 02/25/1987
5) [X] Male
[ ] Female

Information about the physician or other health care professional

6) Name of physician or other health care professional

7) If treatment was given away from the worksite, where was it given?
Facility MED UNIV OF S.C. - TRAUMA UNIT
Street 5 DOUGHTY STREET
City CHARLESTON State SC Zip 29425

8) Was employee treated in an emergency room?
[X] Yes
[ ] No

9) Was employee hospitalized overnight as an in-patient?
[ ] Yes
[X] No

Information about the case

Form approved OMB no. 1218-0176

10) Case number from the Log 5 *(Transfer the case number from the Log after you record the case.)*
11) Date of injury or illness 11/20/2004
12) Time employee began work 04:00 AM
13) Time of event 12:15 PM [ ] Check if time cannot be determined

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
COMMUNICATIONS MAN ON WIRE PULLING CREW.

15) **What happened?** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
WIRE TUGGER PULLED LOOSE FROM ITS MOORINGS AND WHIPPED UP AND HIT DON LEMEN IN THE UPPER BACK.

16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
BLUNT FORCE TRAUMA TO THE UPPER BACK RESULTING IN DEATH.

17) **What object or substance directly harmed the employee?** Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.
WIRE TUGGER.

18) **If the employee died, when did death occur?** Date of death 11/20/2004

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.