

**OSHA INFORMATION  
for  
Metro Electric Co., Inc.**

<b>YEAR:</b>	<b>2005</b>
<b>TOTAL MANHOURS WORKED:</b>	<b>182,968</b>
<b>TOTAL NUMBER OF RECORDABLES:</b>	<b>1</b>
<b>NUMBER OF LOST WORKDAY (ONLY) CASES:</b>	<b>0</b>
<b>NUMBER OF RESTRICTED WORKDAY (ONLY) CASES:</b>	<b>0</b>
<b>NUMBER OF FATALITIES:</b>	<b>0</b>
<b>NUMBER OF 1ST AID (ONLY) CASES:</b>	<b>3</b>
<b>EXPERIENCE MODIFICATION RATE (EMR):</b>	<b>.87</b>
<b>TOTAL CASE INCIDENT RATE (TCIR):</b>	<b>1.09</b>
<b>LOST WORKDAY CASE INCIDENT RATE (LWCIR):</b>	<b>0.00</b>



METRO ELECTRIC COMPANY INC

NAME OF RISK

EFFECTIVE DATE

07/30/05

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 O IJ F	9 ACT INC LOSSES	10 ACT PRI LOSSES
CARRIER 5190	1196	19	POLICY NO 2300620	200100536	7800	EFF-DATE 90203260	07/30/01 6 F	EXP-DATE 2101	07/30/02 2101
5606	130	18	165150	60276	11452	50208280	6 F	7907	5000
3810	014	22	707250	2147	386				
3940			PREMIUM CREDIT FOR ( 0 )	990	218				
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									
CARRIER 5190	12238	19	POLICY NO 2820728	WC2581508	21	EFF-DATE 23825561	07/30/02 5 F	EXP-DATE 11120	07/30/03 5000
5606	130	18	172710	73903	14042				
3810	014	22	739315	2245	404				
3940			PREMIUM CREDIT FOR ( 0 )	1035	228				
POLICY-TOTAL 3732753				(SUBJECT PREMIUM = 128998 )				11120	
AS REQUIRED BY THIS STATE, ACTUAL INCURRED LOSSES FROM THIS POLICY ARE NET OF DEDUCTIBLE RECOVERIES AND EXPECTED LOSSES ARE GROSS OF ANY DEDUCTIBLE									
CARRIER 5190	12238	19	POLICY NO 2579553	WC2581508	21	EFF-DATE 23828374	07/30/03 4 F	EXP-DATE 29461	07/30/04 5000
5606	130	18	175235	67584	12841	23832266	4 O	99173	5000
3810	014	22	862864	2278	410	23829465	6 F	2556	2556
3940			ADDITIONAL PREMIUM ( 0 )	1208	266				
3940			PREMIUM CREDIT FOR ( 0 )	( 0 )	( 0 )				
POLICY-TOTAL 3617752				(SUBJECT PREMIUM = 147265 )				131190	
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)	(J)
023		171419	211666	40247	125626	36900		143523	17897

Total by Policy Year of all cases \$2,000 or less.

Limited loss.  
Catastrophic loss.  
Disease Loss.  
Employers Liability Loss.

(11) PRIMARY LOSSES (12) STABILIZING VALUE (13) RATABLE EXCESS (14) TOTALS

ACTUAL	(I)	(C) X (1-W) + (G)	(A) X (F)	(J)
17897		168893	28894	215684
EXPECTED	(E)	(A) X (C)	(K)	(15) EXP.MOC (J) / (K)
40247		39426	248566	0 87

NUMBER 2  
DATE 03/18/05

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# OSHA's Form 300A

## Summary of Work Related Injuries and Illnesses



Year 2005

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

### 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 66

Total hours worked by all employees last year 182,968

### 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.

Richard Buck  
Company executive

Hum. Resources  
Title

(843) 554-0621

Phone 01/09/06

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.

### Information about the employee

- 1) Full Name EDDIE J DANGERFIELD
- 2) Street 522 MOSSY HILL LANE  
City SUMMERVILLE State SC Zip 29483
- 3) Date of birth 06/22/1972
- 4) Date hired 09/28/1994
- 5)  Male  
 Female

### Information about the physician or other health care professional

- 6) Name of physician or other health care professional WORKSITE PARTNERS
- 7) If treatment was given away from the worksite, where was it given?  
Facility WORKSITE PARTNERS  
Street 1741 SPEISSEGGER DRIVE  
City N CHARLESTON State SC Zip 29405

Completed by	<u>Lee Ann Ecle</u>
Title	<u>Executive Assistant</u>
Phone	<u>803-584-0621</u>
Date	<u>01/09/06</u>

### Information about the case

Form approved OMB no. 1218-0176

- 10) Case number from the Log 6  
(Transfer the case number from the Log after you record the case.)
- 11) Date of injury or illness 11/9/2005
- 12) Time employee began work 07:00 AM
- 13) Time of event 10:00 AM  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." PULLING WIRE.

- 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."  
WHILE THE EMPLOYEE WAS PULLING WIRE, HE DEVELOPED A STRAIN TO LOWER 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."  
LOW BACK STRAIN

- 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.  
N/A

- 18) If the employee died, when did death occur? Date of death

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.