

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

YEAR:	2006
TOTAL MANHOURS WORKED:	206,541
TOTAL NUMBER OF RECORDABLES:	1
NUMBER OF LOST WORKDAY (ONLY) CASES:	0
NUMBER OF RESTRICTED WORKDAY (ONLY) CASES:	0
NUMBER OF FATALITIES:	0
NUMBER OF 1ST AID (ONLY) CASES:	5
EXPERIENCE MODIFICATION RATE (EMR):	.92
TOTAL CASE INCIDENT RATE (TCIR):	0.97
LOST WORKDAY CASE INCIDENT RATE (LWCIR):	0.00



WORKERS COMPENSATION EXPERIENCE RATING
METRO ELECTRIC COMPANY INC

EFFECTIVE DATE 07/30/06

NAME OF RISK

RISK IDENT. NO 390190166

STATE SOUTH CAROLINA

1	2	3D-	4	5	6	7	8	9	10
CODE	ELR	RATI	PAYROLL	EXPECTED LOSSES	EXP PRIM LOSSES	CLAIM DATA	O IJ F	ACT INC LOSSES	ACT PRIM LOSSES
CARRIER 12238			POLICY NO	WC258150821		EFF-DATE	07/30/02	EXP-DATE	07/30/03
5190	262	19	2820728	73903	14042	23825561	5 F	11120	5000
5606	130	18	172710	2245	404				
8810	014	22	739315	1035	228				
9940	PREMIUM CREDIT FOR ()			(0)	(0)				
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 12238			POLICY NO	WC258150821		EFF-DATE	07/30/03	EXP-DATE	07/30/04
5190	262	19	2579553	67584	12841	23828374	4 F	29461	5000
5606	130	18	175235	2278	410	23832266	4 F	30608	5000
8810	014	22	862964	1208	266	23829465	6 F	2556	2556
9808	ADDITIONAL PREMIUM ()			(0)	(0)				
9940	PREMIUM CREDIT FOR ()			(0)	(0)				
POLICY-TOTAL			3617752	(SUBJECT PREMIUM = 147265)				62625	
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 15660			POLICY NO	WC202258101		EFF-DATE	07/30/04	EXP-DATE	07/30/05
5190	262	19	3269174	85632	46274	1015485	1 F	241957	5000
5606	130	18	207800	2701	486				
8810	014	22	1042784	1460	321				
9812	ADDITIONAL PREMIUM ()			(0)	(0)				
9940	PREMIUM CREDIT FOR ()			(0)	(0)				
POLICY-TOTAL			4519758	(SUBJECT PREMIUM = 198407)				241957	
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									
***** **** REVISED RATING **** *****									
RATING REVISED TO REFLECT APPROVED RATING VALUES (ARAP) IF APPL : 1 00									
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	
024		192794	238066	45272	204689	39975		225456	20767

* Total by Policy Year of all cases \$2,000 or less.
Limited loss.
C Catastrophic loss.
D Disease Loss.
E 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)	(15) EXP.MOD.
20767		186498	49125	256390	(J) / (K)
EXPECTED	(E)	(A) X (C)	(K)		
45272		186498	46271	278041	0 92

PAGE NUMBER 1
DATE 10/05/06

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OSHA's Form 300A

Summary of Work Related Injuries and Illnesses



Year 2006

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)	(1) Injury	(4) Poisoning
0	0	0
(2) Skin Disorder	(5) Hearing loss	
0	0	
(3) Respiratory Condition	(6) All other illnesses	
0	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-3844, 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 P O BOX 71228
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)	1 7 3 1
Employment information	
Annual average number of employees	45
Total hours worked by all employees last year	206,541
Sign here	
I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.	
<i>[Signature]</i>	Exec Assz
Company executive	Title
843-5540621	1-17-07
Phone	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 Spec. Asst.
Phone 813-554-0621 Date 1-17-07

Information about the employee

- 1) Full Name RONALD A. CONNICK
- 2) Street 1154 TIDAL VIEW LANE
City CHARLESTON State SC Zip 29412
- 3) Date of birth 08/17/1955
- 4) Date hired 02/27/1977
- 5) Male
 Female

Information about the physician or other health care professional

- 6) Name of physician or other health care professional ERIC STEM, MD
- 7) If treatment was given away from the worksite, where was it given?
Facility SC SPORTS MEDICINE
Street 9100 MEDCON STREET
City NORTH CHARLE State SC Zip 29406-9167

8) Was employee treated in an emergency room?

Yes
No

9) Was employee hospitalized overnight as an in-patient?

Yes
No

Information about the case

- 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 10/17/2006
- 12) Time employee began work 07:00
- 13) Time of event 12:00 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 OUT COLD SHRINK INSULATION FROM JUNCTION BOX

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."
TAB BROKE FROM COLD SHRINK AND HIS HAND SLIPPED AND HIT BOX. FINGER BLEED

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."
LACERATION TO THE SIDE OF RIGHT HAND - THIRD DIGIT

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.
JUNCTION BOX

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.