

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

<b>YEAR:</b>	<b>2007</b>
TOTAL MANHOURS WORKED:	197,990
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:	0
EXPERIENCE MODIFICATION RATE (EMR):	.95
TOTAL CASE INCIDENT RATE (TCIR):	1.01
LOST WORKDAY CASE INCIDENT RATE (LWCIR):	0.00



NAME OF RISK

RISK IDENT. NO 390190166

EFFECTIVE DATE 07/30/07

STATE SOUTH CAROLINA

1	2	3	4	5	6	7	8	9	10
CODE	ELR	RATI	PAYROLL	EXPECTED LOSSES	EXP PRIM LOSSES	CLAIM DATA	IJ F	ACT INC LOSSES	ACT PRIM LOSSES
CARRIER 125190	238	16	POLICY NO 2579553	WC258150821	71454	11433	EFF-DATE 07/30/03	EXP-DATE 07/30/04	
5606	112	14	175235	1963	275	23828374	4 F	29461	5000
8810	021	17	862964	1812	308	23832266	4 F	30680	5000
9808			ADDITIONAL PREMIUM	( 0 )	( 0 )	23829465	6 F	2556	2556
9940			PREMIUM CREDIT FOR	( 0 )	( 0 )				
POLICY-TOTAL				3617752	(SUBJECT PREMIUM = 146461)			62697	
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	16	14	POLICY NO 3269174	WC202258101	90556	14489	EFF-DATE 07/30/04	EXP-DATE 07/30/05	
5190	277	16	207800	2827	326	1015485	1 F	241957	5000
5606	112	14	207800	2827	326				
8810	021	17	1042784	2190	372				
9812			ADDITIONAL PREMIUM	( 0 )	( 0 )				
9940			PREMIUM CREDIT FOR	( 0 )	( 0 )				
POLICY-TOTAL				4519758	(SUBJECT PREMIUM = 157561)			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									
CARRIER 15660	16	14	POLICY NO 3035644	WC202258102	84087	13454	EFF-DATE 07/30/05	EXP-DATE 07/30/06	
5190	277	16	205400	2300	322	1050381	6 F	390	390
5606	112	14	205400	2300	322				
8810	021	17	1059294	2225	378				
9812			ADDITIONAL PREMIUM	( 0 )	( 0 )				
9941			PREMIUM CREDIT FOR	( 0 )	( 0 )				
POLICY-TOTAL				4300330	(SUBJECT PREMIUM = 206595)			390	
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 **** *****									
REVISED RATING TO INCLUDE UPDATED DATA FOR:									
(A)	(B)	(C)	EXPECTED EXCESS (D-E)	(D)	(E)	(F) ACTUAL EXCESS (H-I)	(G)	(H)	(I)

\* 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)
EXPECTED	(E)		(A) X (C)	(K)
				(15) EXP.MOD. (L) / (K)

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DATE 04/23/07


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NAME OF RISK

EFFECTIVE DATE 07/30/07

RISK IDENT. NO 390190166

STATE SOUTH CAROLINA

1	2	3	4	5	6	7	8	9	10
CODE	ELR	RATI	PAYROLL	EXPECTED LOSSES	EXP PRIM LOSSES	CLAIM DATA	I J F	ACT INC LOSSES	ACT PRIM LOSSES
SC CORRECTION(S) (C-1) FOR POL					#: WC202258101,			EFF : 07/30/04	
SC CORRECTION(S) (C-1) FOR POL					#: WC202258102,			EFF : 07/30/05	
									
(ARAP) IF APPL : 1 00									
(A)	(B)	(C) EXPECTED EXCESS (D-E)	(D)	(E)	(F) ACTUAL EXCESS (H-I)	(G)	(H)	(I)	
021		217557	258914	41357	259141				
* Total by Policy Year of all cases \$2,000 or less. # Limited loss. C Catastrophic loss. D Disease Loss. E Employers Liability Loss.									

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DATE 04/23/07

	(11) PRIMARY LOSSES	(12) STABILIZING VALUE	(13) RATABL EXCESS	(14) TOTALS
ACTUAL	(I) 15884	(C) X (1-W) + (D) 218895	(A) X (F) 54420	(J) 289199
EXPECTED	(E) 41357	218895	(A) X (C) 45687	(K) 305939

(15) EXP. MOD.  
(J) / (K)  
0 95

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# OSHA's Form 300A

## Summary of Work Related Injuries and Illnesses

Year 2007



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
1	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-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 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 71  
Total hours worked by all employees last year 197,990

### 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  
Title Exec Asst

Phone 843-554-0621 Date 1-3-08

# 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 information 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	<i>[Signature]</i>
Title	<i>Exec. Assistant</i>
Phone	<i>843-554-0621</i>
Date	<i>1-3-08</i>

### Information about the employee

- 1) Full Name DANYL H KNAGENHJELM
- 2) Street 1004 REDBANK ROAD L-5  
City GOOSE CREEK State SC Zip 29445
- 3) Date of birth 02/09/1981
- 4) Date hired 04/08/2002
- 5)  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 \_\_\_\_\_
- Street \_\_\_\_\_
- City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

- 8) Was employee treated in an emergency room?

Yes	<input type="checkbox"/>
No	<input checked="" type="checkbox"/>

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

Yes	<input type="checkbox"/>
No	<input checked="" type="checkbox"/>

### Information about the case

- 10) Case number from the Log 7 (Transfer the case number from the Log after you record the case.)
- 11) Date of injury or illness 02/13/2007
- 12) Time employee began work 06:30
- 13) Time of event 10:00  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."

REACHING UP TO HANG BRACKET AND ARM RIGHT ABOVE THE WRIST TOUCHED STEE

- 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."

CUT RIGHT ARM ON STEEL STUD OF BLDG FRAME

- 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."

2 IN CUT ON RIGHT ARM

- 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.

STEEL BEAM

- 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.