

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

YEAR:	2008
TOTAL MANHOURS WORKED:	199,647
TOTAL NUMBER OF RECORDABLES:	2
NUMBER OF LOST WORKDAY (ONLY) CASES:	0
NUMBER OF RESTRICTED WORKDAY (ONLY) CASES:	0
NUMBER OF FATALITIES:	0
NUMBER OF 1ST AID (ONLY) CASES:	2
EXPERIENCE MODIFICATION RATE (EMR):	.88
TOTAL CASE INCIDENT RATE (TCIR):	2.00
LOST WORKDAY CASE INCIDENT RATE (LWCIR):	0.00



WORKERS COMPENSATION EXPERIENCE RATING

METRO ELECTRIC COMPANY INC

NAME OF RISK

EFFECTIVE DATE 07/30/08

RISK IDENT. NO 390190166

STATE SOUTH CAROLINA

1 CODE	2 ELR	3D-RATI	4 PAYROLL	5 EXPECTED LOSSES	6 EXP PRIM LOSSES	7 CLAIM DATA	8 O IJ F	9 ACT INC LOSSES	10 ACT PRIM LOSSES
CARRIER 15660 POLICY NO WC202258101									
5190	297	14	3269174	97094	13593	EFF-DATE 1015485	07/30/04 1 F	EXP-DATE 241957 #	07/30/05 5000
5606	108	14	207800	2244	314				
8810	024	15	1042784	2503	375				
9812	ADDITIONAL PREMIUM		(0)	(0)					
9940	PREMIUM CREDIT FOR		(0)	(0)					
POLICY-TOTAL 4519758				(SUBJECT PREMIUM = 197381)				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 POLICY NO WC202258102									
5190	297	14	3035644	90159	12622	EFF-DATE 1050381	07/30/05 6 F	EXP-DATE 390	07/30/06 390
5606	108	14	205400	2218	311				
8810	024	15	1059294	2542	381				
9812	ADDITIONAL PREMIUM		(0)	(0)					
9941	PREMIUM CREDIT FOR		(0)	(0)					
POLICY-TOTAL 4300338				(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									
CARRIER 15660 POLICY NO WC202258103									
5190	297	14	3369662	100079	14011	EFF-DATE 1090380	07/30/06 6 F	EXP-DATE 692	07/30/07 692
5606	108	14	195370	2110	295	1080402	6 F	1331	1331
8810	024	15	1083462	2600	390				
9812	ADDITIONAL PREMIUM		(0)	(0)					
9841	DRUG FREE CREDIT		(5239)	(735)					
9940	PREMIUM CREDIT FOR		(0)	(0)					
POLICY-TOTAL 4648494				(SUBJECT PREMIUM = 227888)				2023	
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									
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	
022		254753	296310	41557	233000	52250	238724	5724	

METRO
 JUN 1 2008
 JOB #

* 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	(II) 5724	(IC) X (1-W) + (IG) 250957	(AJ) X (IF) 51260	(JI) 307941	(15) EXP. MOD. (J) / (K) 0 88
EXPECTED	(IE) 41557	250957	(AI) X (IC) 56046	(IK) 348560	

PAGE NUMBER 2
 DATE 06/03/08

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Year 2008

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

Form approved OMB no. 1218-0176

OSHA's Form 300A Summary of Work Related Injuries and Illnesses

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

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

North American Industrial Classification (NAICS), if known (e.g., 36212)

1 7 3 1

Employment information

Annual average number of employees 62
 Total hours worked by all employees last year 199,647

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.

843-534-0621
 Phone
1-7-09
 Date



OSHA's Form 301 Injuries and Illnesses Incident Report

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

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.

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 _____
Title _____
Phone _____ Date _____

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.

Information about the employee

- 1) Full Name WILLIAM PAUL GRIMES
- 2) Street 237 BRAILSFORD ROAD State SC Zip 29485
- City SUMMERVILLE
- 3) Date of birth 10/11/1983
- 4) Date hired 03/05/2007
- 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 OWENSBORO MEDICAL HEALTH SYSTEM

Street 811 EAST PARRISH AVENUE

City OWENSBORO State KY Zip 42303

- 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 9 (Transfer the case number from the Log after you record the case.)
- 11) Date of injury or illness 07/02/2008
- 12) Time employee began work 07:00
- 13) Time of event 11:00 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 WIRE OUT OF PIPE

- 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." PULLING WIRE AND FELT A STRAIN

- 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." LOWER 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. PULLING WIRE AND FELT BACK PULL

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



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.

Form approved OMB no. 1218-0176
(Transfer the case number from the Log after you record the case.)

Information about the case

- 10) Case number from the Log 8
11) Date of injury or illness 03/05/2008
12) Time employee began work 07:00
13) Time of event 02:30

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."

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." PULLED MUSCLES/LIGAMENTS IN LEFT SHOULDER.

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. A MISSTEP THROUGH HIM OFF ENOUGH TO STRAIN HIS LEFT SHOULDER.

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

Information about the employee

- 1) Full Name MARK J. SIMMONS
2) Street 5263 JURY LANE
City NORTH CHARLESTON State SC Zip 29418
3) Date of birth 03/29/1959
4) Date hired 07/05/1994
5) [X] Male [] Female

Information about the physician or other health care professional

- 6) Name of physician or other health care professional DR. ROBINSON
7) If treatment was given away from the worksite, where was it given?
Facility WORKSITE PARTNERS
Street 149 ST JAMES AVENUE
City GOOSE CREEK State SC Zip 29445

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

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

OSHA's Form 301
Injuries and Illnesses Incident Report

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Completed by _____
Title _____
Phone _____ Date _____