

## Workplace Safety and Loss Prevention Incentive Program Safety Program Annual WSLPIP Report

Workplace Safety and Loss Prevention Incentive Program (WSLPIP) credits are granted for a three year approval period. To receive the incentive credit in the second and third years of the approval period, you must submit this report (SH 930) to the Department of Labor (DOL). It is due no later than 90 days after your annual policy renewal date, at the beginning of years two and three of the incentive. The deadline is March 31<sup>st</sup> for self-insured employers.

You can renew the incentive credit at the end of the three-year approval period. Submit this report with the renewal application to the DOL. Do this no later than 90 days **prior** to the policy renewal date. The deadline is no later than 90 days **prior** to the end of the calendar year for self-insured employers.

Incentive Certificate Number: \_\_\_\_\_ Issue date: \_\_\_ / \_\_\_ / \_\_\_ Expiration date: \_\_\_ / \_\_\_ / \_\_\_

### Section A: Employer Information

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ NAICS: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Number of employees: \_\_\_\_\_

FEIN: \_\_\_\_ - \_\_\_\_\_

### Section B: Workers' Compensation Insurance Information

Provide the information for the workers' compensation policy for which you are seeking the incentive credit. Fill out one report per policy.

Insurer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Annual policy renewal date: \_\_\_ / \_\_\_ / \_\_\_ Experience rating (current policy year): \_\_\_\_\_

Annual insurance premium: \_\_\_\_\_ Contact person: \_\_\_\_\_

Title: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_ Policy number: \_\_\_\_\_

Experience rating (previous policy year): \_\_\_\_\_ Check box if self-insured

Annual security deposit (if self-insured): \_\_\_\_\_

**Section C: Company Location(s) Information**

Give the physical address for all locations covered by the workers' compensation policy listed in Section B. Use Appendix A (SH 933) to list additional locations.

Company Location	Management Contact Name	Management Contact Phone	No. of Employees	Employee Representative
		(____) ____ - ____		
		(____) ____ - ____		
		(____) ____ - ____		
		(____) ____ - ____		
		(____) ____ - ____		

**Section D: Employee Representative(s) Information**

Use Appendix A (SH 933) to list additional employee representatives.

Employee Representative (#1):	Bargaining Unit (if applicable):
Work location:	Phone number: (____) ____ - ____
Employee Representative (#2):	Bargaining Unit (if applicable):
Work location:	Phone number: (____) ____ - ____
Employee Representative (#3):	Bargaining Unit (if applicable):
Work location:	Phone number: (____) ____ - ____

**Section E: Designated Program Contact**

Enter information for the person designated for employees to contact about the program.

Name: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Work location: \_\_\_\_\_ E-mail address: \_\_\_\_\_

**Section F: Employer Claim Information**

Report any claims filed within the last year. Also report any open claims from any previous year. Include the corresponding classification and severity. Injury classifications are: caught by; caught in-between; struck by; hearing loss; slip or trip; fall; lung related disease, back injury, and electrical shock. Injury severity types are: death; permanent total disability; permanent partial disability; temporary total disability; and medical only. Use Appendix A (SH 933) to list additional injuries.

Total number of claims	Experience rating

Reported injury	Primary NAICS	Severity of Injury
	— — — — —	
	— — — — —	
	— — — — —	
	— — — — —	
	— — — — —	

**Section G: Program Improvements and Training**

Provide the following information about your Safety Program.

1. Describe the new or improved safety measures implemented as a result of the Safety Program:

2. List the investments made in safety equipment as part of your Safety Program:

3a. How many accidents did not result in a workers' compensation claim? \_\_\_\_\_

b. How did the program prevent and/or lessen the severity and frequency of accidents in the previous and current policy years? To what degree did the program help?

4a. How many employees returned to work following a workplace accident, injury or illness? \_\_\_\_\_

b. How many employees were unable to return to work following a workplace accident, injury or illness?  
\_\_\_\_\_

5a. How many employees were given training about the Safety Program this year? \_\_\_\_\_

b. How many supervisors were given training about the Safety Program this year? \_\_\_\_\_

- c. List the dates of training. For each date, list the number of employees who were trained. Also give a description of the specific activities and materials used for training.

## Section H: Employer Verification

Each employer that applies for credits under the WSLPIP must verify that:

- the information about the WSLPIP on this report is true and accurate,
- the employer's program(s) meet(s) program requirements, and
- the employer agrees to continue to operate the program(s) in accordance with the law.

A verification is a statement made by an authorized agent of an employer under the penalty of perjury.

The employer confirms that it has complied with all requirements of these regulations concerning the participation of employee representatives. This includes designated employee representatives and the recognized representative of each collective bargaining unit, where applicable. These requirements can be found in sections 60-1.6, 60-1.2, and 60-1.8 of the law.

In addition, the employer certifies that the information contained in this application is accurate and true and that the Incentive Program implemented, as indicated in this application, meets the requirements of the Workplace Safety and Loss Prevention Incentive Program as required by Sections 60-1.13.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

By checking this box, you indicate that you fully understand the liabilities associated with providing your signature and employer verification.

### Continuance of the Incentive

DOL will review an employer's Annual WSLPIP Report. Once the report is approved, DOL will issue a notification of review and approval to the employer. The employer must send a copy of this notification to the insurer in a timely manner. If the employer is self-insured, the notification must be sent to the Workers' Compensation Board.

### Approval, monitoring and appeal

- (a) Applications for Incentives may be denied, revoked, or suspended if the Department determines that the employer failed to implement and/or maintain a WSLPIP that complies with the law.
- (b) Any approved Workplace Safety and Loss Prevention Incentive Program is subject to monitoring. Monitoring may include responding to complaints, on-site visits, discussions with employee representatives (including designated employee representatives or the recognized representative of each collective bargaining unit) and review of all WSLPIP records and documents requested by the Department.
- (c) If an employer's application is denied, revoked or suspended, the employer may appeal the denial under Article 78 of the civil practice law and rules.

Send this completed Annual WSLPIP Report to:

New York State Department of Labor  
Workplace Safety and Loss Prevention Program  
1220 Washington Ave., Building 12, Room 167  
Albany, NY 12226  
<https://dol.ny.gov/workplace-safety-loss-prevention>