



# TAC Safety Award Application

County or Organization Name: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Position: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## COUNTY ASSESSMENT

- 1 All participating members must complete the award application.**
  - I want to be considered for the Safety Award.
  - I would like to schedule a visit with our loss control representative to discuss the safety award criteria.
  
- 2 Safety Resolution**
  - Adopted     Not sure
  
- 3 Loss Ratio <75 percent**
  - Our loss ratio is at or below the threshold                       Do not know
  - Would like to learn more how to reduce our loss ratio
  
- 4 Accident Prevention Plan**
  - We have an active accident prevention plan                       We have a plan but we may need assistance
  - Not sure
  
- 5 Seat Belt Policy**
  - We have a seat belt policy                       We do not have one
  - Not sure     N/A
  
- 6 Regulatory Compliance Training**

Hazard Communication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure	<input type="checkbox"/> N/A
Bloodborne Pathogens	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure	<input type="checkbox"/> N/A
CDL Drug Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure	<input type="checkbox"/> N/A

