Georgia Department of Labor

AWARD OF EXCELLENCE

Purpose

The Georgia Department of Labor sponsors the annual awards program to promote safe, healthy work environments in Georgia and recognize and honor the employers and employees who make them a reality.

Qualification

The "Award of Excellence" will be given to any employer in the public or private sector who has experienced at least 250 workdays during the previous calendar year with no "days away from work" due to workplace injuries or illnesses.

Definitions

Calendar Year

January 1 - December 31 (Previous year)

Workday

Eight hours of work performed by the workers of a company. Each 8-hour shift may count as a workday. Three 8-hour shifts or two 12-hour shifts count as 3 workdays.

Day Away From Work

A day in which an injured worker was not in attendance or providing a valuable service at a workplace designated by the employer.

Employer

A company, organization or institution as a whole or any geographically or organizationally distinct operation thereof. The operation/facility applying for the award must be located in the state of Georgia.

Employee

A person who works for an entity in return for financial or other compensation, regardless of whether the person is a salaried or hourly worker.

The application for the award of excellence can be found at ***www.georgiaconference.org***.

AWARD OF EXCELLENCE

GEORGIA DEPARTMENT OF LABOR
MARK BUTLER
COMMISSIONER

Equal Opportunity Employer/Program • Auxiliary Aids & Services Are Available Upon Request To Individuals With Disabilities

APPLICATION

Name of the "Employer" as you want it to appear on the award ____________________

____

Name of Contact Person ____________________

Title ____________________

Mailing Address ____________________

____

____

Phone No. ____________________ Fax No. ____________________

Email Address ____________________

Number of employees at this Georgia location __________ Number of workdays per week (See definitions) __________

Is this a division of a larger entity? ❑ Yes ❑ No If so, please provide the name. ____________________

What product or service does this employer manufacture or provide? ____________________

____

CERTIFICATION

We hereby certify that ____________________ *(Employer)*

experienced __________ *(250 days minimum)* workdays with no employee losing a day from work due to a workplace injury, illness or fatality. (The 250 days do not have to be consecutive.)

Person responsible for maintaining records of workplace injuries, illnesses and fatalities.

Signature ____________________ Print Name ____________________

Title ____________________

Person responsible for management of this "Employer" location.

Signature ____________________ Print Name ____________________

Title ____________________

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