



# ENROLLMENT FORM

In an effort to reduce the number of workplace accidents and to share resources and information on accident prevention, risk management and workers' compensation in Ohio, the BWC's Division of Safety & Hygiene and your local safety council co-sponsor this program.

**In signing this enrollment form, the employer makes a commitment to send representatives to the majority of safety council meetings and to submit semi-annual reports by the deadline dates.**

Enrollment Date: \_\_\_\_\_

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

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Average Number of Employees: \_\_\_\_\_ Type of Work: \_\_\_\_\_

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

BWC Policy Number: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_

To be completed by the Safety Council.

**Safety Council Account Number**

(Must be completed before forwarding to DSH)

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Licking County Chamber of Commerce  
50 West Locust Street, P.O. Box 702  
Newark, Ohio 43058-0702  
Phone: 740-345-9757