



Jet Propulsion Laboratory
California Institute of Technology

**Attachment 5
Experience Modification Rate (EMR)**

**Experience Modification Rate (EMR)
Recordable Incident Rate / Lost-Time Incident Rate**

This form must be completed and submitted to JPL. The intent of this form is to measure and evaluate each Subcontractor's frequency, severity, and incident rates as they relate to workers compensation insurance claims. The EMR (Experience Modification Rate) is a number established by insurance carriers to accurately adjust an individual company's workers compensation insurance premiums based on industry average workers compensation insurance claims for their respective NAICS (North American Industry Classification System). Recordable and lost-time incident rates are used to measure and evaluate a company's frequency, severity, and incident rates as they relate to occupational related injuries and illnesses. In addition to the information provided below, please attach copies of your OSHA 300, 301, and 300A forms for each of the three respective years.

Subcontractor Name: _____ **Date:** _____

Project Name: _____ **Subcontract No.:** _____

NAICS / SIC No.: _____

| Recordable Injuries / Illnesses Data | | | | | |
|--------------------------------------|------|------------------|--------------------------------------|-------------------------------|--------------------------|
| | Year | Total Hrs worked | No. of Recordable Injuries/Illnesses | Total days of restricted work | Recordable Incident Rate |
| Year 1: | | | | | |
| Year 2: | | | | | |
| Year 3: | | | | | |

| Loss-Time Injuries / Illnesses Data | | | | | |
|-------------------------------------|------|--------------------|-------------------------------------|----------------------|-------------------------|
| | Year | Total Hours worked | No. of Lost-Time Injuries/Illnesses | Total Lost Work Days | Lost-Time Incident Rate |
| Year 1: | | | | | |
| Year 2: | | | | | |
| Year 3: | | | | | |

(insert Company name) _____ does not have an EMR.

| Workers Compensation EMR (Experience Modification Rate) | | | | | |
|---|--|---------|--|---------|--|
| Year 1: | | Year 2: | | Year 3: | |
| Rate: | | Rate: | | Rate: | |

Approval

Authorized Representative: _____ Date: _____

Type/Print Name: _____

Type/Print Title: _____