

Use this worksheet to keep track of actions you would like to take when you return to the workplace and/or your committee activities.

PERSONAL ACTION PLAN

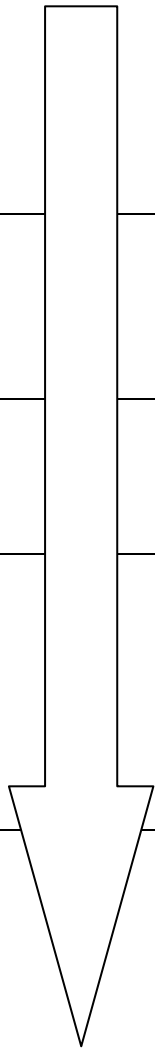
Action Items	Target Date	Completed?

RISK REDUCTION PLANNING WORKSHEET

<i>Hazard</i>

Control Measures

	Category	Control Measures
A T T H E S O U R C E	Elimination	
	Substitution	
A L O N G T H E P A T H	Engineering	
	Administrative	
A T T H E W O R K E R	PPE	



Joint Health & Safety Committee Health and Safety Recommendations Report

To:
Date:
Location:
Committee Members:
Please respond by: (within 21 days)

Issue:

Background

Discussion - Analysis

Conclusions – Health and Safety Recommendations	
Co-chair	Co Chair
Employer Response	
Signature	Date Required

**EXAMPLE OF A RECOMMENDATION
WHICH WOULD GO TO THE EMPLOYER**

Date:	
Location:	
Who is on committee:	
Issue:	Needle Stick Injuries

Background

Five workers employed in community health employed at Alcohol & Drug Services in Kamloops reported needle stick injuries. Information on whether this is a provincial issue or one related to our site is not available at this time. These injuries exposed workers to bloodborne pathogens, which can cause infection. The most important of these are Hepatitis B and C viruses.

Infections to each of these pathogens are potentially life threatening and preventable.

Discussion – Analysis

The workers who have been exposed have suffered emotional impact - with three still being absent from employment. Currently we have not included needle stick injuries as part of the stress counselling program.

In analysing needle stick injuries in the work place we have identified the following injury trends:

Most were as a result of accidental puncture from clients leaving used needles in the wastebasket or in washrooms:

Conclusions – Health and Safety Recommendations

The health and safety committee recommends the following action plan:

1. Workers need to be trained and educated regarding risk factors This could be accomplished at a staff meeting. The duration should be two hours.
2. Promote safety awareness in the work environment We would recommend posters or fact sheets. One a month for four months starting Jan 15, 2008.
3. Establish procedures for reporting and follow-up of needlestick injuries. This is a requirement of the Workers Compensation Act and Regulation section 6.33 Biohazardous material. A copy is attached for your reference.
4. Develop a written exposure control plan designed to eliminate or minimize worker exposure to bloodborne pathogens This is to be done in the next month on a joint basis (worker and employer participation).
5. Change work practises to eliminate worker exposure. Change how frequently garbage is removed.
6. Free hepatitis B vaccinations should be offered to all workers.

If you have any questions or concerns regarding the committee recommendations please do hesitate in contacting either of the two co-chairs of the committee The committee requires a written response within 21 days of this letter. Thanking you in advance for your attention regarding this matter.

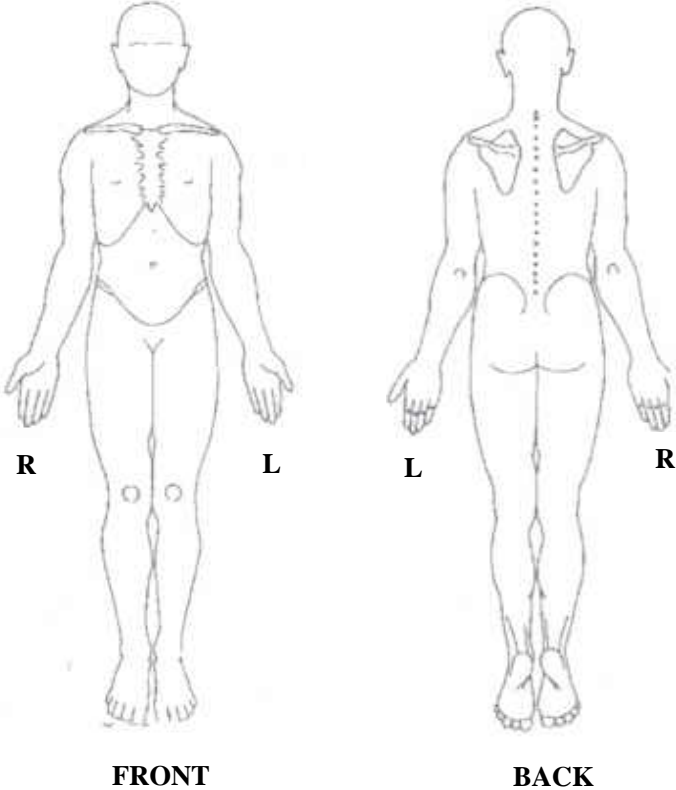
Co chair

Co-chair

Pain and Discomfort Report Form

CHW Name: _____ Date _____

Use this form to report any pain or discomfort to your supervisor for reassessment of the related work task. Contact your Union/Worker OHS Representative for assistance and follow up.

BODY MAP Shade in body parts where you have pain or discomfort	TASK Check (✓) tasks that cause pain or discomfort
	<p>Personal Care:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mouthcare <input type="checkbox"/> Shampoo/shave <input type="checkbox"/> Skincare <input type="checkbox"/> Dressing <input type="checkbox"/> Perineal care <input type="checkbox"/> Catheter care <input type="checkbox"/> Toileting <input type="checkbox"/> Bathing / Bed care <p>Client Handling</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dressing / Changing <input type="checkbox"/> Assisted walking <input type="checkbox"/> Turning in bed <input type="checkbox"/> Use of mechanical lift <p><i>Repositioning:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> In bed <input type="checkbox"/> In chair <p><i>Transferring:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> from: _____ to: _____ <input type="checkbox"/> from: _____ to: _____ <input type="checkbox"/> from: _____ to: _____ <p>Meals / Activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prepare meals <input type="checkbox"/> Feeding client <input type="checkbox"/> Grocery shopping <input type="checkbox"/> Adult Day Care <input type="checkbox"/> On-going appointments <p>Cleaning / Household:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bed change <input type="checkbox"/> Laundry <input type="checkbox"/> Vacuuming <input type="checkbox"/> Cleaning: _____ <input type="checkbox"/> Floors (kitchen/bath)

Comment on the movement or activity that aggravates the pain or discomfort. E.g. rolling the resident in bed

- Is your pain or discomfort persistent?
- Getting worse?
- Does it affect your ability to work?
- Is it new and related to a specific incident?

ERGONOMICS QUESTIONNAIRE FOR WORKERS

Yes	No	Does the work require repetitive Motions	Yes	No	Is there enough room
Yes	No	Does the work require twisting motions	Yes	No	Is there enough light
Yes	No	Does the work require reaching motions	Yes	No	Is there glare
Yes	No	Does it require working with bent neck or spine	Yes	No	Is it noisy
Yes	No	Does it require unnatural or uncomfortable positions or motions of the back, neck, arms, legs, shoulders	Yes	No	Are the chairs, beds, desks, other furniture adjustable to allow a better fit for different people
Yes	No	Does it require substantial flexibility, strength and endurance	Yes	No	Is training provided on safe handling procedures
Yes	No	Can the work be done without unusual physical efforts	Yes	No	Must materials, or clients be moved
Yes	No	Can the job be changed to avoid long periods of time in one position or constant repetitive motion	Yes	No	Can materials be easily gripped or held
Yes	No	Is the workplace designed for comfort and ease of motion	Yes	No	How much do they weight_____
Yes	No	Does the work cause muscles to get tired, weak or sore	Yes	No	Does the work require repetitive motions
Yes	No	Is there a better layout of equipment, materials and work areas	Yes	No	Are they awkward
Yes	No	What is their shape	Yes	No	What is their size
Yes	No	Where are they stored	Yes	No	Does it require lifting to and from high spots
Yes	No	Does it require lifting to and from low spots	Yes	No	Are the necessary equipment and mechanical devises used (eg patient lift devices)
Yes	No	Does it require pushing or pulling	Yes	No	Are injuries reported immediately
Yes	No	How far must they be moved	Yes	No	____To the supervisor
Yes	No	Is the housekeeping good	Yes	No	____to the health and safety committee
Yes	No	Is the walkway clear of tripping hazards	Yes	No	____to the WCB
Yes	No	Is the walkway clear of bumping hazards	Yes	No	____Occupational First Aide Attendant
Yes	No	Is the walkway clear of slipping hazards	Yes	No	Are the causes of injuries determined and are hazards corrected to prevent future accidents
Yes	No	Do the workers have a clear, unobstructed field of vision	Yes	No	Is your workplace gloomy and dull
Yes	No	Can they see where they must go	Yes	No	Are they allowed enough time to do the job safely
Yes	No	Is there sufficient break time to rest	Yes	No	Is there excessive overtime
Yes	No	Is extra help available	Yes	No	

Indoor air quality complaint form

Fill out this form to make a complaint related to indoor air quality. Indoor air quality complaints include concerns about temperature, ventilation, and air pollutants.

Return the completed form to _____

or call _____ to make your complaint by phone.

We try to respond to indoor air quality complaints as quickly as we can.

Date _____

Name _____ Title _____

Telephone _____

Department and location in building _____

Describe the nature of the complaint and any potential causes. _____

Office use only

Complaint # _____ Received by _____ Date received _____

Walkthrough inspection checklist

Date _____

Name of inspector(s) _____

Department or location inspected _____

Reason for inspection _____

Inspection activity	Notes
<ul style="list-style-type: none"> ▪ If necessary, include other individuals in the investigation (for example, the supervisor of the area you are investigating or a member of the joint health and safety committee). ▪ Talk to the building occupants who made the complaints. Discuss the nature and timing of their symptoms. Ask them to identify any suspected causes ▪ Check for obvious pollutant sources such as humidifiers, new furniture or new carpets. ▪ Check the HVAC system: <ul style="list-style-type: none"> - check thermostat settings - check that thermostats, diffusers, fans and dampers are clean and operating properly - check the outdoor air intake for mould, stagnant water, blockage, or nearby sources of contaminants. ▪ Take measurements, if necessary, using thermometers, direct reading carbon dioxide meters, or other equipment. ▪ Check Records: <ul style="list-style-type: none"> - when was the system last calibrated and adjusted. - when was preventive maintenance last performed 	

Possible causes of problem

Recommended corrective action

Corrective action taken? Yes No

Additional investigation required: Yes No

HVAC checklist

This checklist is from Building Air Quality: A guide for Building Owners and Facility Managers, December 1991 (EPA Publication No 400/1-91/003, NIOSH Publication No 91-144). The full publication, as well as a longer version of the form, is available at: www.cdc.gov/niosh/baqtoc.html.

Building name _____ Address _____

Completed by: _____ Date _____

Mechanical room

- Clean and dry? _____ Stored refuse or chemicals? _____
- Describe items in need of attention _____

Major mechanical equipment

- Preventive maintenance (PM) plan in use? _____

Control System

- Type _____
- System operation _____
- Date of Last calibration _____

Boilers

- Rated Btu input _____ Condition _____
- Combustion air: Is there a least one square inch free area per 2,000 Btu input? _____
- Fuel or combustion odors? _____

Cooling Tower

- Clean? No leaks or overflow? _____ Slime or algae growth? _____
- Eliminator performance _____
- Biocide treatment working? (list type of biocide) _____
- Spill containment plan implemented? _____ Dirt separator working? _____

Chillers

- Refrigerant leaks? _____
- Evidence of condensation problems? _____
- Waste oil and refrigerant properly stored and disposed of? _____

Air handling unit

- Unit identification _____ Area served _____

Outdoor Air Intake, Mixing Plenum, and Damper

- Outdoor air intake location _____
- Nearby contaminant sources? (described) _____
- Bird screen in place and unobstructed? _____
- Design total cfm _____ Outdoor air (O.A.) cfm _____ Date last tested and balanced _____
- Minimum % O.A. (damper setting) _____ Minimum cfm O.A. = (total cfm X min. % O.A.) ÷ 100 = _____
- Current O.A. damper setting (date, time, and HVAC operating mode) _____
- Damper control sequence (describe) _____
- Condition of dampers and controls (note date) _____

Fans

- Control sequence _____
- Condition (note date) _____
- Indicated temperatures: _____ supply air _____ mixed air _____ return air _____ outdoor air _____
- Actual temperatures: _____ supply air _____ mixed air _____ return air _____ outdoor air _____

Coils

- Heating fluid discharge temperature ____ T ____ cooling fluid discharge temperature ____ T ____
- Controls (describe) _____
- Condition (note date) _____

Humidifier

- Type _____ if biocide is used, note type _____
- Condition (no overflow, drains trapped, all nozzles working?) _____
- No slime, visible growth, or mineral deposits? _____

Distribution System

Zone/room	System type	Supply Air		Return Air		Power Exhaust		
		ducted/ unducted	cfm	ducted/ unducted	cfm	Cfm	Control	Serves (eg toilet)

Condition of distribution system and terminal equipment (note locations of problems)

- Adequate access for maintenance? _____
- Ducts and coils clean and unobstructed? _____
- Air paths unobstructed? Supply ____ return ____ transfer ____ exhaust ____ make-up ____

Occupied Space

Thermostat types

Zone/Room	Thermostat Location	What Does Thermostat Control? (e.g., radiator, AHU-3)	Setpoints		Measured Temperature	Day/ Time
			Summer	Winter		

Humidistats/dehumidistats type

Zone/Room	Humidistat / Dehumidistat Location	What Does It Control?	Setpoints (% RH)	Measured Temperature	Day / Time

- Potential problems (note location): _____

- Thermostat comfort or air circulation (drafts, obstructed airflow, stagnant air, overcrowding, poor thermostat location) _____

- Malfunctioning equipment _____
- Major sources of odors or contaminants (e.g. poor sanitation, incompatible uses of space) _____

Discharged Air

Ventilation systems that discharge air from work areas must be designed to minimize the likelihood of exposing any worker at a workplace, including an adjacent workplace, to:

- An air contaminant in a concentration that exceeds 10% of its applicable exposure limit or an acceptable ambient air quality standard, whichever is greater.
- An objectionable odour, where practicable

This requirement applies to process exhaust and all exhaust from spaces where air contaminants are generated, including combustion products from space and water heaters and tobacco smoke from designated smoking areas. For a complete list of air contaminants and their exposure limits, see the Occupational Health and Safety Regulation.

Air cleaning equipment or exhaust stacks may be used to meet discharged air requirements. Process controls that reduce emissions to below odour thresholds or detection limits may be able to

A properly functioning HVAC system:

- Provides thermal Comfort
- Distributes adequate amounts of outdoor air
- Removes odours and contaminants

Community Health Worker Hazard Report Form

CHW Name: _____ Date: _____

Client Name: _____

Client Address: _____

If you observe hazards (conditions in your workplace that may place you at risk or injury, you must report them to your supervisor. Your employer must respond to any such reports to ensure that the potential health and safety risk is eliminated or minimized to make the work safe.

Use this form to report hazards to your Supervisor and/or Union OHS Representative for follow up and reassessment. Do not use this form to report an injury.

MSI Hazards	
<input type="checkbox"/> Experiencing pain or discomfort <input type="checkbox"/> Change In client's level of ability <input type="checkbox"/> Tasks are physically demanding: <ul style="list-style-type: none"> <input type="radio"/> transferring <input type="radio"/> repositioning <input type="radio"/> personal care <input type="radio"/> cleaning <input type="checkbox"/> Other	Describe:
Chemical Hazards	
Consumer Product Name	What do you use it for?

Biological Hazards and Infection Control	
<input type="checkbox"/> Needles <input type="checkbox"/> Incontinence of bowel or bladder <input type="checkbox"/> Pet waste <input type="checkbox"/> Vermin / infestations <input type="checkbox"/> Other	Describe:
Violence	
<input type="checkbox"/> Verbal treats or abuse* <input type="checkbox"/> Physical assaults or aggression* <input type="checkbox"/> Sexual advances criminal activity* <input type="checkbox"/> Pets <input type="checkbox"/> Environment (e.g. blocked exits) <input type="checkbox"/> Other :	Describe:
Working Alone	
<input type="checkbox"/> No communication method <input type="checkbox"/> No set check-in procedure <input type="checkbox"/> Other:	Describe
General Hazards	
<input type="checkbox"/> Poor road conditions <input type="checkbox"/> Poor lighting <input type="checkbox"/> Clutter present <input type="checkbox"/> Slip and trip hazards present <input type="checkbox"/> Stairs or walkways in poor condition <input type="checkbox"/> Air quality concerns (eg. smoking, mould) <input type="checkbox"/> Electrical or fire hazards present <input type="checkbox"/> Weapons present Other:	Describe

**Occupational Health & Safety (OHS)
Community Health Care**

HOME VISIT/CALL OUT SAFETY CHECKLIST

Date of inspection: _____

Worker representative _____

Employer representative: _____

Date of inspection: _____	Yes	No	N/A	Comment
Worker representative _____				
Employer representative: _____				
HOME VISIT & CALLOUT				
Risk assessments of client and home are undertaken before committing employees and / or volunteers to a home visit or call-out.				
Higher risk clients are seen by staff in pairs (this can include staff from another community service organization).				
Has the organization written procedures on how to conduct an assessment.				
Pets and other animals are restrained for the duration of the visit.				
Employees / volunteers carry official ID which identifies the issuing community service.				
Employees / volunteers have been instructed to withdraw from a visit if they feel at risk.				
Employees / volunteers who work alone or in isolated situations are provided with a duress alarm or mobile phone or call in system.				
Employees / volunteers are trained in procedures on client sites e.g. maintaining clear line of exit, keeping car keys and diary secure and parking the car to facilitate an easy exit?				
Incidents on client premises are documented in client files and in incident reports?				
Procedures are communicated to all employees / volunteers to avoid walking in deserted places or taking shortcuts.				

OUTSIDE RESIDENCE	Yes	No	N/A	Comment
Parking – adequate parking on street				
Gates – easy to open				
Pathway - level				
• non-slip				
• uncluttered				
Steps / stairs - level				
• non-slip				
• uncluttered				
Verandah surface - level				
• non-slip				

OUTSIDE RESIDENCE	Yes	No	N/A	Comment
• uncluttered				
Pets				
• restrained				
• separated from worker				
Door clear of obstruction				

INSIDE RESIDENCE	Yes	No	N/A	Comment
Floor surfaces :				
• Level				
• Non-slip				
• Uncluttered				
Lighting – Adequate for walking				
• Adequate for performing work?				
Do the tasks involve working at a height?				
Emergency exit – visible with easy access?				
Smoke detector/s – present and working?				

BATHROOM/TOILET	YES	NO	N/A	COMMENT
Toilet				
• Adequate room				
Drainage - adequate to ensure non-slip floor?				
Ventilation - adequate to ensure fresh air?				
Electrical equipment - not used in bathroom?				

KITCHEN	YES	NO	N/A	COMMENT
Electrical equipment –				
• Cords not frayed or damaged				
• Not used near water				
• Non-slip floor surface				
• Tagged where appropriate				
Table/benches - Appropriate height				
Chairs - Stable				
• Appropriate height				

CLIENT HANDLING	YES	NO	N/A	COMMENT
Employees know the signs and symptoms of an MSI				
MSI risk assessments (including moving clients) are completed and current				
Equipment is in place to assist with transferring and repositioning clients.				
Rooms are arranged to eliminate or minimize risks.				
Tasks are designed to eliminate or minimize risks.				

CHARACTERISTICS OF LOAD AND EQUIPMENT	Yes	No	N/A	Comment
Where the "object" concerned is a person:				
•do they need to be moved in a special way to ensure their health & safety?				
•might the person be disturbed, excited or be moving vigorously (uncontrolled movements)				

INANIMATE OBJECTS	Yes	No	N/A	Comment
Is the object an awkward shape to carry in a balanced posture?				
Is the object difficult to grasp or hold safely?				
Is the object unstable or unbalanced, or				
Is the object smooth, slippery, greasy or wet?				
Can the contents move suddenly?				
Does the object have sharp edges or protrusions?				
Is the object very hot or cold?				
Does the object block the view of the employee while being handled?				
Does one person handle large sized loads without the assistance of straps, special holders or a second person ?				
Is the object more than 50cm wide (measured in direction across the body)?				
Is the object difficult to lift or carry close to the body?				

INFECTION CONTROL	YES	NO	N/A	COMMENT
Employees have received training in safe work procedures				
Employees are emergency procedures if stuck by a needle or exposed to blood.				
Safe sharp disposal containers are available and accessible.				
PPE (and training in its use) is provided.				

HAZARDOUS SUBSTANCES	YES	NO	N/A	COMMENT
Substances labeled appropriately?				
Substances in original container?				
Used for the purpose it was designed for?				
Stored in safe position?				
Gloves / other protection available if required?				
Exhaust fan / open window/ventilation adequate?				
Health effects / emergency procedures known?				
Material Safety Data Sheets (MSDS) available?				

OTHER ISSUES	YES	NO	N/A	COMMENT
Manual handling assessment required? (if yes, complete & attach)				
Other Electrical Equipment (i.e. vacuum cleaner, floor polisher) – Tested and Tagged?				

Occupational Health & Safety (OHS)

Community Health Care

EXTERNAL ENVIRONMENT SAFETY & SECURITY CHECKLIST

Venue:

Date & time:

Check completed by:

Date for review:

VEHICLE PARKING AREA & BUILDING PERIMETER	Yes	No	N/A	Action
Landscaping provides minimal hiding places.				
Entrance and exits clearly marked.				
Surface of parking area and the driveways free from potholes, cracks and other trip hazards.				
Well drained areas to prevent flooding and pooling of water.				
Direction of traffic well defined, traffic and speed restriction signs clearly defined and free from obstructions.				
Adequate lighting installed and operational.				
Intersections and pedestrian areas identified.				
'No Parking' areas well sign posted.				
Disabled parking designated and clearly marked.				
Emergency and service vehicle parking designated and clearly marked.				

PEDESTRIAN WALKWAYS AND ACCESS POINTS	Yes	No	N/A	Action
Continuous clear accessible pathway i.e. no barriers				
No raised curbs or changes in the pathways.				
Landscaping provides minimal hiding places.				
Adequate illumination of walkways, stairways and ramps.				
Surface free of holes and projections.				
Well drained area to prevent flooding.				
Anti-slip surfaces, fungus build-up treated.				
Steps and changes of level clearly defined.				
Emergency entrance and exits clear, well defined and lit.				
Walls, gates and fences in good order without gaps or protrusions.				
Childproof locks fitted to gates where needed.				

FLOORS / AISLES / EXITS	Yes	No	N/A	Action
Entrances/steps in good order.				
Hand rails where appropriate.				
Floor coverings in good repair.				
Floors even, uncracked, no holes.				
Floors clean and not slippery.				
Signs to indicate wet floor after cleaning.				
Entrances, doorways and stairs kept clear.				
Walkways free from rubbish.				

STAIRS AND LANDINGS	Yes	No	N/A	Action
Lighting adequate.				
Good visual contrasts between steps.				
Slip resistant strips on edge of steps.				
Handrails present and at correct height.				
Stairwells and exits well illuminated.				

BATHROOMS / TOILETS	Yes	No	N/A	Action
Adequate toilets for male/female.				
Toilets for people with disabilities provided.				
Hand washing facilities available.				
Sanitary bins provided.				
Accessible light switches.				

FIRST AID	Yes	No	N/A	Action
First aid kit complete as required.				
Name of first aid officer clearly displayed.				
Current first aid certificate held by first aid officer.				
Register of injuries kept.				
Employees/volunteers provided with personal protective equipment for cleaning, e.g. disposable gloves.				

COMMUNICATION	Yes	No	N/A	Action
Employees / volunteers have communication equipment such as mobile phone.				
Communication equipment is checked prior to leaving base.				
Communication equipment is switched on at all times off-site and programmed for back-to-base and emergency numbers.				
Employees / volunteers leave records of off site visit addresses, scheduled arrival and departure times and registration number of vehicle.				
Employees / volunteers report movements to base as agreed in protocols (e.g., regular call-in on arrival or departure, or at end of shift)				
Procedures in place if contact is lost or off-site employee / volunteer fails to return when expected.				
Code words established for off-site employee / volunteer to signify they are in a threatening situation.				
Off-site employees / volunteers carry contact details for police, fire and ambulance services.				

HOME VISIT & CALLOUT	Yes	No	N/A	Action
Risk assessments of client and home are undertaken before committing employees and/or volunteers to a home visit or call-out.				
Higher risk clients are seen by staff in pairs (this can include staff from another community service organization).				
Pets and other animals are restrained for the duration of the visit.				
Employees / volunteers carry official photo ID which				

HOME VISIT & CALLOUT	Yes	No	N/A	Action
identifies the issuing community service.				
Employees / volunteers are respectful to the client and aware that the client may perceive them to be invading their personal space.				
Employees / volunteers have been instructed to withdraw from a visit if they feel at risk.				
Employees / volunteers who work alone or in isolated situations are provided with a duress alarm or mobile phone or call in system.				
Employees / volunteers are trained in procedures on client sites e.g., maintaining clear line of exit, keeping car keys and diary secure and parking car to facilitate exit.				
Incidents on client premises are documented in client files and in incident reports.				
Procedures are communicated to all employees / volunteers to avoid walking in deserted places or taking shortcuts.				

WORKING ON OTHER PREMISES	Yes	No	N/A	Action
Employees / volunteers working in other sites such as community buildings or schools are made aware of the security and emergency procedures of those premises				
Security in the external and internal environment should be checked prior to employees / volunteers using the premises				

TRANSPORT SAFETY – VEHICLES	Yes	No	N/A	Action
Employees / volunteers hold valid drivers licenses for the class of vehicle.				
Licenses are recorded and verified annually.				
Records of vehicle registration, insurance, fuel, mileage and servicing and parts replacement are maintained and regularly checked.				
A roadside assistance scheme such as NRMA is in place for all facility vehicles.				
Prior to leaving base drivers check fuel levels and visually inspect the vehicle e.g. tires, lights and indicators.				
Vehicles are routinely serviced and a fault reporting / recording mechanism is in place.				
Random checks are conducted for vehicle condition and safety.				
Information is kept in each facility vehicle with instructions, a report card, first aid advice, and emergency telephone numbers.				
An incident reporting and investigation system is in place.				
Safety devices are considered prior to vehicle purchase or lease such as dual front seat air-bags, side airbags in driver seat, anti-lock breaking systems, three point seat belts, and adjustable head rests.				
Passenger safety issues are considered prior to bus purchase or lease such as: •hydraulic devices, •fold down steps •handles to assist passengers to get on and off •secure wheelchair and shopping storage, •				

seatbelts, •sufficient room between seats and •slip resistant steps and floor surfaces.				
Cargo barrier in place in station wagons and hatchbacks.				
Heavy or bulky freight stored in boot or separated from passengers by cargo barriers.				
Procedures in place for drivers of vehicle such as speed limits, fatigue management, alcohol and drug use.				
Mobile telephone use in vehicles is not allowed unless the vehicle has been pulled over.				
Procedures in place for requirements and minimum standards for private vehicles that are used for work purposes e.g. insurance status, maintenance and is regularly checked for currency.				
Are the facility vehicles equipped with first aid kits, fire extinguishers, safety triangles and safety vests.				
Emergency procedures in place and communicated to workers / volunteers.				

TRANSPORTING CLIENTS	Yes	No	N/A	Action
Client profile is assessed prior to transport and if necessary an additional escort is provided				
Drivers who are not familiar with the client are to be provided with information regarding the client so that they are aware of physical and behavioural limitations.				
Means of emergency communication are accessible in the vehicle.				
Drivers are trained in emergency procedures such as pull over, immobilize car, retreat to a safe place and call for back-up.				
Potential weapons such as cigarette lighters are removed and objects such as fire extinguishers are stored in the boot.				
Employees and volunteers who regularly transport clients are trained in first aid.				
Drivers are aware of location of medical centres and emergency departments in areas where they are transporting clients.				
Clients wear seatbelts where fitted.				
Child-proof locks are used when transporting children and clients with dementia.				
Ensure that employees and volunteers who transport clients in private vehicles have comprehensive insurance and notify their insurance company of the activity.				
Employees and volunteers are trained in manual handling techniques specific to moving people with physical limitations or disabilities and equipment such as wheelchairs, in and out of vehicles.				
Wheelchairs used for client transportation are lightweight and designed for portability.				

Other	Yes	No	N/A	Action

Occupational Health & Safety (OHS) Community Health Care

VIOLENCE SAFETY CHECKLIST

Use the sample check list below to develop a violence safety check list which is relevant to your workplace. A 'Yes' answer indicates that the matter is in order. A 'No' answer indicates that the matter should be assessed and controlled. List all the 'No' answers in order of priority. Determine the priority by the seriousness and the frequency of the risks posed. The check should be carried out by management in consultation with employees.

Clients	Yes	No	Comment
Are there procedures for referring clients to other services for psychiatric, drug and alcohol and behavioral reasons?			
During admission is referral information being verified?			
Are there written admission criteria for clients?			
Are written admission procedures used in assessment of clients?			
Are clients made aware of their responsibilities and those of staff?			

Staff rosters	Yes	No	Comment
Do the staff always work in pairs?			
Specify sole worker times			
How many staff is available for each 24 hour period?			
Does the roster avoid back to back shifts for staff?			
Does the current staff level prevent excessive overtime?			

Staff training	Yes	No	Comment
Have all staff undergone the following training:			
o Client service skills?			
o How to identify, assess and resolve conflict?			
o Negotiation skills?			
o Armed hold-up survival?			
o Anger management?			
o Crisis communication?			
o Post trauma debriefing procedure?			
o Accident and incident reporting?			
o Fire drills and emergency procedure?			

Callouts	Yes	No	Comment
Callout procedure exists and is current?			
Are there written procedures for callouts?			
Are there code words which alert staff by phone that staff members on a callout are in trouble?			
Is home base staff familiar with emergency support procedures?			

Security equipment and facilities	Yes	No	Comment
Do the premises have the following equipment and facilities?			
o Duress alarms in offices and interview rooms.			
o Security and fire alarms.			
o Sprinkler systems or smoke alarms.			
o Fire fighting equipment which complies with Fire Department guidelines.			
o Security screens for windows and doors.			
o Master key locking systems.			
o Outdoor security lights triggered to operate after dark.			
o Hidden safes.			
o Interview rooms with two exits.			
o Staff exits from office areas.			
o Parking facilities which are close by, well lit and with minimal shrubbery.			

Environment	Yes	No	Comment
Throughout the premises:			
o Is there diffuse, glare free lighting?			
o Is there adequate space for staff and clients?			
o Are noise levels within a reasonable limit?			
o Are the interior wall colours subdued?			

Communication	Yes	No	Comment
Is there one telephone that cannot be accessed by clients?			
Do staff members on duty have the capacity to contact each other easily?			
Are mobile phones, intercoms, duress alarms and beepers available and in good working order?			
Are telephone numbers of all emergency services displayed prominently above all telephones and are on automatic dial?			
Is there one telephone that can be used by clients?			
In remote locations have procedures been implemented that:			
o Allow for personal ID call signs			
o Established communication times			

Procedures	Yes	No	Comment
Is there a procedure for?			
o Handling disputes between clients.			
o Confiscating items which could be used as a weapon from clients.			
o Cash handling.			
o Securing the premises.			
o The safe storage of personal property.			
o Responding to alarms.			
o The issue of medication including record keeping.			
o After major and minor violent incidents.			
o Dealing with bomb threats.			

**Occupational Health & Safety (OHS)
Community Health Care**

EXTERNAL ENVIRONMENT SAFETY & SECURITY CHECKLIST

Venue: _____

Date & time: _____

Check completed by: _____

Date for review: _____

VEHICLE PARKING AREA & BUILDING PERIMETER	Yes	No	N/A	Action
Landscaping provides minimal hiding places.				
Entrance and exits clearly marked.				
Surface of parking area and the driveways free from potholes, cracks and other trip hazards.				
Well drained areas to prevent flooding and pooling of water.				
Direction of traffic well defined, traffic and speed restriction signs clearly defined and free from obstructions.				
Adequate lighting installed and operational.				
Intersections and pedestrian areas identified.				
'No Parking' areas well sign posted.				
Disabled parking designated and clearly marked.				
Emergency and service vehicle parking designated and clearly marked.				

PEDESTRIAN WALKWAYS AND ACCESS POINTS	Yes	No	N/A	Action
Continuous clear accessible pathway i.e. no barriers				
No raised curbs or changes in the pathways.				
Landscaping provides minimal hiding places.				
Adequate illumination of walkways, stairways and ramps.				
Surface free of holes and projections.				
Well drained area to prevent flooding.				
Anti-slip surfaces, fungus build-up treated.				
Steps and changes of level clearly defined.				
Emergency entrance and exits clear, well defined and lit.				
Walls, gates and fences in good order without gaps or protrusions.				
Childproof locks fitted to gates where needed.				

FLOORS / AISLES / EXITS	Yes	No	N/A	Action
Entrances/steps in good order.				
Hand rails where appropriate.				
Floor coverings in good repair.				
Floors even, uncracked, no holes.				
Floors clean and not slippery.				
Signs to indicate wet floor after cleaning.				
Entrances, doorways and stairs kept clear.				
Walkways free from rubbish.				

STAIRS AND LANDINGS	Yes	No	N/A	Action
Lighting adequate.				
Good visual contrasts between steps.				

STAIRS AND LANDINGS	Yes	No	N/A	Action
Slip resistant strips on edge of steps.				
Handrails present and at correct height.				
Stairwells and exits well illuminated.				

BATHROOMS / TOILETS	Yes	No	N/A	Action
Adequate toilets for male/female.				
Toilets for people with disabilities provided.				
Hand washing facilities available.				
Sanitary bins provided.				
Accessible light switches.				

FIRST AID	Yes	No	N/A	Action
First aid kit complete as required.				
Name of first aid officer clearly displayed.				
Current first aid certificate held by first aid officer.				
Register of injuries kept.				
Employees/volunteers provided with personal protective equipment for cleaning, e.g. disposable gloves.				

COMMUNICATION	Yes	No	N/A	Action
Employees / volunteers have communication equipment such as mobile phone.				
Communication equipment is checked prior to leaving base.				
Communication equipment is switched on at all times off-site and programmed for back-to-base and emergency numbers.				
Employees / volunteers leave records of off site visit addresses, scheduled arrival and departure times and registration number of vehicle.				
Employees / volunteers report movements to base as agreed in protocols (e.g., regular call-in on arrival or departure, or at end of shift)				
Procedures in place if contact is lost or off-site employee / volunteer fails to return when expected.				
Code words established for off-site employee / volunteer to signify they are in a threatening situation.				
Off-site employees / volunteers carry contact details for police, fire and ambulance services.				

HOME VISIT & CALLOUT	Yes	No	N/A	Action
Risk assessments of client and home are undertaken before committing employees and/or volunteers to a home visit or call-out.				
Higher risk clients are seen by staff in pairs (this can include staff from another community service organization).				
Pets and other animals are restrained for the duration of the visit.				
Employees / volunteers carry official photo ID which identifies the issuing community service.				
Employees / volunteers are respectful to the client and aware that the client may perceive them to be invading their personal space.				
Employees / volunteers have been instructed to withdraw from a visit if they feel at risk.				
Employees / volunteers who work alone or in isolated situations are provided with a duress alarm or mobile phone				

HOME VISIT & CALLOUT	Yes	No	N/A	Action
or call in system.				
Employees / volunteers are trained in procedures on client sites e.g., maintaining clear line of exit, keeping car keys and diary secure and parking car to facilitate exit.				
Incidents on client premises are documented in client files and in incident reports.				
Procedures are communicated to all employees / volunteers to avoid walking in deserted places or taking shortcuts.				
WORKING ON OTHER PREMISES	Yes	No	N/A	Action
Employees / volunteers working in other sites such as community buildings or schools are made aware of the security and emergency procedures of those premises				
Security in the external and internal environment should be checked prior to employees / volunteers using the premises				

TRANSPORT SAFETY – VEHICLES	Yes	No	N/A	Action
Employees / volunteers hold valid drivers licenses for the class of vehicle.				
Licenses are recorded and verified annually.				
Records of vehicle registration, insurance, fuel, mileage and servicing and parts replacement are maintained and regularly checked.				
A roadside assistance scheme such as NRMA is in place for all facility vehicles.				
Prior to leaving base drivers check fuel levels and visually inspect the vehicle e.g. tires, lights and indicators.				
Vehicles are routinely serviced and a fault reporting / recording mechanism is in place.				
Random checks are conducted for vehicle condition and safety.				
Information is kept in each facility vehicle with instructions, a report card, first aid advice, and emergency telephone numbers.				
An incident reporting and investigation system is in place.				
Safety devices are considered prior to vehicle purchase or lease such as dual front seat air-bags, side airbags in driver seat, anti-lock breaking systems, three point seat belts, and adjustable head rests.				
Passenger safety issues are considered prior to bus purchase or lease such as: •hydraulic devices, •fold down steps •handles to assist passengers to get on and off •secure wheelchair and shopping storage, • seatbelts, •sufficient room between seats and •slip resistant steps and floor surfaces.				
Cargo barrier in place in station wagons and hatchbacks.				
Heavy or bulky freight stored in boot or separated from passengers by cargo barriers.				
Procedures in place for drivers of vehicle such as speed limits, fatigue management, alcohol and drug use.				
Mobile telephone use in vehicles is not allowed unless the vehicle has been pulled over.				
Procedures in place for requirements and minimum standards for private vehicles that are used for work purposes e.g. insurance status, maintenance and is regularly checked for currency.				
Are the facility vehicles equipped with first aid kits, fire				

extinguishers, safety triangles and safety vests.				
Emergency procedures in place and communicated to workers / volunteers.				

TRANSPORTING CLIENTS	Yes	No	N/A	Action
Client profile is assessed prior to transport and if necessary an additional escort is provided				
Drivers who are not familiar with the client are to be provided with information regarding the client so that they are aware of physical and behavioural limitations.				
Means of emergency communication are accessible in the vehicle.				
Drivers are trained in emergency procedures such as pull over, immobilize car, retreat to a safe place and call for back-up.				
Potential weapons such as cigarette lighters are removed and objects such as fire extinguishers are stored in the boot.				
Employees and volunteers who regularly transport clients are trained in first aid.				
Drivers are aware of location of medical centers and emergency departments in areas where they are transporting clients.				
Clients wear seatbelts where fitted.				
Child-proof locks are used when transporting children and clients with dementia.				
Ensure that employees and volunteers who transport clients in private vehicles have comprehensive insurance and notify their insurance company of the activity.				
Employees and volunteers are trained in manual handling techniques specific to moving people with physical limitations or disabilities and equipment such as wheelchairs, in and out of vehicles.				
Wheelchairs used for client transportation are lightweight and designed for portability.				

Other	Yes	No	N/A	Action


Sample Inspection Form

Occupational Safety & Health Inspection Form

Date: _____ Location: _____

Inspected by: _____ (employer Rep.)

Inspected by: _____ (worker Rep)

Area	Unsafe Condition/Health Hazard	Correction Action Required & Person(s) Responsible	Disposition (e.g. Follow/up Completion Date)
			

Home Care Risk Assessment Tool

Client Name _____ Assessed by _____ Date: _____

Section A - MSI Risk Assessment

This is a reassessment.

	TASK	✓ CHW Assists	Identify hazards, injury prevention control measures, and instructions to CHW	✓ No issues
Personal Care	Bathing			
	Bed bath / sponge bath			
	Bath tub / shower			
	Skincare			
	Shampoo/Shave			
	Mouthcare			
	Toileting			
	Perineal Care			
Patient Handling	Dressing/Changing			
	Assisted Walking			
	Repositioning in chair			
	Repositioning in bed			
	Use of lift equipment: floor lift or ceiling lift			
	Transfers			
	From: To:			
	From: To:			
From: To:				
DOT				

Signature: _____ Date: _____

Client Name: _____ Assessed by: _____ Date: _____

TASK		✓ CHW Assists	Identify hazards, injury prevention control measures, and instructions to CHW	✓ No issues
Meals	Prepare meals			
	Assist client with eating			
Out-of-Home	Assist client In and out of vehicles			
	Walking outside			
	Grocery Shopping			
	Adult Day Care			
	Routine appointments			
Cleaning and Household Activities	Bed change			
	Laundry			
	Dusting			
	Vacuuming			
	Defrost and Clean Fridge			
	Clean Oven			
	Kitchen cleaning / floor			
	Bathroom cleaning / floor			
	Interior window			
	Other cleaning tasks			

Signature: _____

Date: _____

Section B – Assistive Devices

This is a reassessment.

Client Name: _____ **Assessed by:** _____ **Dated:** _____

EQUIPMENT	✓ If in Place	✓ If needed	Comments: does equipment need repair? Does equipment need to be installed? Who responsible? Implementation date? Who will follow up and when?	✓ No issues
Wheelchair(s): Manual				
Powered				
Scooter				
Walker: standard or wheeled				
Cane				
Crutches				
Raised Toilet Seat				
Toilet Rail				
Commode				
Hand-held Shower				
Hospital Bed (circle) Manual / Electric With rails / without rails				
Transfer/Reposition Devices: Grab Bars				
Bath / Shower: Bench or stool				
Bed Ladder				
Transfer Slide Sheet				
Transfer Board				
Transfer Belt				
Transfer Disc				
Transfer Pole(s)				
Floor Lift				
Ceiling Lift				
Other				

Signature: _____ **Date:** _____

Section C - Chemical Hazards

This is a reassessment.

Client Name: _____ **Assessed by:** _____ **Date:** _____

Product Name – List products CHW will use in home	Indicate health hazard, injury prevention control measures, and instructions to CHW. Attach additional page if more space is required.	✓ No issues

Section D – Biological Hazards and Infection Control

This is a reassessment.

Infectious disease source: <input type="checkbox"/> Client <input type="checkbox"/> Other household member <input type="checkbox"/> No Issues Name/describe the disease: Potential transmission routes:		
CHW exposure risk identification	Preventive control measures	Additional instructions to CHW
Airborne pathogens: <input type="checkbox"/> infectious client sneezing/coughing <input type="checkbox"/> sneezing/coughing on handled objects <input type="checkbox"/> disrupted dust/animal waste Blood and body fluids <input type="checkbox"/> sharps (needles, razors) in the home <input type="checkbox"/> catheter care / pericare <input type="checkbox"/> handling biohazardous waste <input type="checkbox"/> handling contaminated laundry/bedding <input type="checkbox"/> handling of Other Potentially Infectious Materials (OPIMs) <input type="checkbox"/> presence of cytotoxic drugs	<input type="checkbox"/> Use safety engineered devices <input type="checkbox"/> Use designated sharp container <input type="checkbox"/> Compliance with Universal Precaution <input type="checkbox"/> Hygiene practice <input type="checkbox"/> Hand washing technique <input type="checkbox"/> Use double gloves where appropriate Use PPE, including: <input type="checkbox"/> gloves <input type="checkbox"/> gowns <input type="checkbox"/> mask or respirator <input type="checkbox"/> goggles <input type="checkbox"/> face shields <input type="checkbox"/> shoe covers <input type="checkbox"/> Other controls, specify:	<input type="checkbox"/> Required safe work procedures. Specify: <input type="checkbox"/> Training and education required. Specify: <input type="checkbox"/> Other instructions:
<input type="checkbox"/> Food Safe: cross contamination in food prep		
Pet waste:		
Vermin (e.g.: rodents, insects)		

Signature: _____ **Date** _____

Section E – Violence and Working Alone

This is a reassessment.

Client Name: _____ Assessed by: _____ Date: _____

VIOLENCE - Risks Client related <input type="checkbox"/> Non client related <input type="checkbox"/>	<input checked="" type="checkbox"/> present or history	Describe risks, injury prevention control measures, and instructions to CHW. Identify who the risks apply to.	<input checked="" type="checkbox"/> No issues
Verbal Aggression Against CHW			
Aggression With / Against Objects			
Physical Aggression Against CHW			
Sexual Abuse			
Other (state type)			
Pets:			
Community Profile <input type="checkbox"/> Evidence of obvious criminal activity. Description			
Unauthorized visitors <input type="checkbox"/> Yes <input type="checkbox"/> No Description:			

WORKING ALONE - Risks	Describe risks, injury prevention control measures, and instructions to CHW	<input checked="" type="checkbox"/> No issues
Isolated Workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No Description: (i.e., remote, rural, limited communications, etc) <input type="checkbox"/> Location remote or rural <input type="checkbox"/> Location off the main roads, at a dead-end, or has limited daily traffic <input type="checkbox"/> Parking is more than one block away or in an underground garage <input type="checkbox"/> Limited or unreliable communications <input type="checkbox"/> No safe location from which to call for assistance. <input type="checkbox"/> Limited access by walking or bus (transportation); evening/night visits <input type="checkbox"/> Obstructions /entrapment areas that limit ability to get away safely (e.g. shrubs, fences yard clutter, etc.)		
CHW is able to communicate with the supervisor or employer via (tick all that apply) <input type="checkbox"/> Telephone at client's home <input type="checkbox"/> Cell phone <input type="checkbox"/> Pay phone located @ _____ <input type="checkbox"/> Other (state):		

Signature: _____ Date: _____

CLIENT SERVICE INFORMATION

Client Goal for Service _____

Hearing: _____ Aids: L R Vision : _____ Glasses: Yes NoContinent: Bowel Yes No Bladder Yes No Continence Pad Yes No
Mobility Independent Supervised (Stand By) Verbal Cueing Minimal Assist (1 Person Transfer)
 Moderate Assist (1-2 Persons &/or Device) Dependent (No Manual Transfer)

Equipment Wheelchair Scooter Walker Canes
 Other (list): _____

Personal Assistance Bath Shave Transferring Dressing
 Bed bath Shampoo Repositioning Perineal Care
 Sponge bath Skincare Walking Toileting
 Cueing/Coaching: _____ Other: _____
Delegation of Tasks:
General Cleaning Kitchen Laundry Bed Change Vacuum
 Bathroom Shopping Wash Floor Dusting
 Other: _____

Periodic Cleaning Oven Fridge Inside Windows
Meal Preparation: _____**Diet Instructions (Including Allergies):**
Community Support Adult Day Care Home Care Nurse Mental Health Worker Other:
 Handidart Lifeline Rehabilitation Therapist
 Nutritionist Hospice Meals on Wheels
Does the Community Health Worker provide childcare? Yes No

Children's names:

1) _____ DOB _____ Allergies _____

2) _____ DOB _____ Allergies _____

3) _____ DOB _____ Allergies _____

Unauthorized visitors: _____

Other information: _____**Comments:**Copies to: Area Scheduler RN/CC/LPN Accounting Other: _____

MONTHLY SAFETY INSPECTION CHECKLIST

Ministry:

Office Code(s):

Work Site Address:

Inspection Dates:

1st	2nd	3rd	4th

Inspected by:

JOSH Worker Rep:				
JOSH Employer Rep:				
Office Manager/Supervisor:				

Section 1: Safety Program

	1st		2nd		3rd		4th	
	Yes	No	Yes	No	Yes	No	Yes	No
1) Safety discussions are a standing agenda item at Team Meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Staff know who their JOSH committee/representative(s) are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Is there adequate and regular communication with JOSH committee/rep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Bulletin Boards for posting safety information are present and organized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) JOSH committee minutes posted from past 3 consecutive meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) JOSH committee minutes include name and location of members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Inspection Team Comments:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Section 2: Manuals and Education/Personnel

	1st		2nd		3rd		4th		N/A
	Yes	No	Yes	No	Yes	No	Yes	No	
1) All personnel have had Safety Training/Review/Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2) Workers are aware of OHS Web Site on Ministry Intranet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3) Ministry OSH Program Manual Available (hard copy) and current	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Workers have read and signed documentation page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Workers have read and signed review page for Manual Updates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Site specific information has been included (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Monthly Safety Inspection Checklist completed (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Inspection Team Comments:

1 st	
2 nd	

3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Section 3: First Aid

	1st		2nd		3rd		4th		N/A
	Yes	No	Yes	No	Yes	No	Yes	No	
1) Level 1 or Level 2 First Aid Attendant(s) (FAA) certification current	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) FAA(s) has original certificate at worksite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) FAA list and contact number is posted conspicuously throughout the area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) First Aid Accident Record Books being used (Attendant & Office)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) A notice indicating FAA authority and employer responsibility to report injuries is posted by first aid room or on OSH board in no FA room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) First Aid facility is clean, sanitary and FAA list posted on door (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) FAA's kit properly stocked and orderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Office First Aid kit properly stocked as per WCB first aid guidelines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) First Aid Assessment annual review completed: Dated:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) Annual First Aid Drill completed: Dated:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Inspection Team Comments:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Section 4: Fire and Emergency Preparedness

	1st		2nd		3rd		4th		N/A
	Yes	No	Yes	No	Yes	No	Yes	No	
1) Fire Extinguisher annual inspection tag present and dated with last inspection: Dated:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Fire Extinguishers mounted approx. 3' above floor and near exits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Fire Extinguisher operation reviewed. (P.A.S.S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Fire Extinguisher training provide, (if applicable i.e. fire suppression team)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Exit signs displayed and visible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Emergency lighting is in areas where a power failure would create a risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Emergency Exit routes provide unimpeded exit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Emergency desk kits under workstations and meeting rooms desks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9) Evacuation diagrams posted with proper orientation, accurate and current	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10) Workers know their emergency evacuation route and meeting area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11) Flammable materials are controlled around office and under sinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12) Annual Fire Drill done: Dated:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13) Earthquake drills done: Dated: (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) Chief Emergency Warden and alternate designated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15) Emergency Warden(s) and alternate(s) designated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16) Emergency Cabinet/Bag has content list posted and cabinet door locked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Inspection Team Comments:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

**Section 5:
Electrical**

	1st		2nd		3rd		4th		N/A
	Yes	No	Yes	No	Yes	No	Yes	No	
1) Exit signs that are lighted, have both bulbs lit (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Exit signs and emergency lighting power failure battery operational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Breaker Panel - fuses are clearly labeled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4) Electrical cords/power bars in good condition/tied out of the way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5) Lighting appropriate for work area and tubes functioning where appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6) Lockout procedure followed i.e. clearing paper jams in copier/printer/shredder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7) Baseboard heaters are clear of flammables (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Ceramic heaters are not in use as per BCBC recommendations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Inspection Team Comments:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Section 6: Workplace Hazardous Materials Information System (WHMIS)

	1st		2nd		3rd		4th		N/A
	Yes	No	Yes	No	Yes	No	Yes	No	
1) Workers have been trained in WHMIS appropriate to the workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2) All janitorial cleaning containers labeled as per WHMIS requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) MSDS available and updated (Janitor room, and fire extinguisher)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4) All controlled products labeled as per WHMIS requirements (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Appropriate spill procedure(s) posted (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) List of carcinogens posted (if appropriate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Gas tanks secured/handled correctly. (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Inspection Team Comments:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Section 7: Waste and Environment

	1st		2nd		3rd		4th	
	Yes	No	Yes	No	Yes	No	Yes	No
1) Containers for waste and recyclable are used appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Air Quality is good and no dust collecting or obvious smells present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) No adverse health problems noted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Indoor Air Quality complaints are documented and investigated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Environmental tobacco smoke exposure is controlled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Inspection Team Comments:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Section 8: Physical Environment

	1st		2nd		3rd		4th		N/A
	Yes	No	Yes	No	Yes	No	Yes	No	
1) Sufficient space overall and allow safe movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2) Shelving is stable and not overloaded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3) Materials safely stacked (waist height for heavier materials)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4) Sufficient storage room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5) Supplies/boxes stored away from floor/aisles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6) Work space efficiently organized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7) Washroom facilities clean and sanitized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8) Lunch Room clean and free of contaminants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Aisles/passageways 44" wide (24 " minimum exit from workspace)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10) File cabinets do not open into traffic areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11) File cabinets secured to wall if more than 3 drawers high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12) Floors are safe from tripping/slipping hazards and are clean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13) Ground safe from tripping/falling hazards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14) Stairways are clutter free (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15) Handrails/Guardrails are present and in good condition (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16) Stairwell lighting is sufficient (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17) Stairwell steps, treads, runners are in good condition (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18) Outside doors close properly and are secure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Inspection Team Comments:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Office Manager/Supervisor: If NO, please provide compliance details:

1st	
2nd	
3rd	
4th	

Supervisor/Manager Signature:

Date of Compliance:

1st	
2nd	
3rd	
4th	

1st	
2nd	
3rd	
4th	

Distribution: Supervisor/Manager, JOSH Committee, OSH Program Coordinator

INSPECTION FORM

Sample Inspection Form

Occupational Safety and health Inspection Form

Date: _____ Agency _____ Dept/Work Area _____

Inspected by: _____
Employer rep

Inspected by: _____
Worker rep

Area	Unsafe Condition/Health Hazard	Corrective Action Required and Persons(s) Responsible	Disposition (e.g. Follow-up. Completion Date)

CONTENTS OF JOINT ACCIDENT INVESTIGATION FORM

1. Date of Report
2. Name of Agency
3. Location
4. Name of Injured (or ill) Worker
5. Years of Service
6. Time on Present Job
7. Occupation
8. Hours Worked in the past 24 hours.
9. Accident Location (Dept. or Area)
10. Date/Time of Accident/Incident (near miss)
11. Accident Category: Injury or Illness/Equipment Malfunction/Motor Vehicle/Property Damage/Other.
12. Severity of Injury or Illness: No Injury or First Aid Only/Medical Treatment/Disabling/Fatal
13. Nature of Injury or illness
14. Description of Accident or Occupational Disease (RSI)
15. Were Written Safe Work Procedures Established and Available?/Were They Adequate?/Where these Safe Work Procedures Used in training?
16. Basic Cause (and Contributory Factors).
17. Corrective Measures taken and/or Recommended (include Corrective Action Referred to and Date to be completed).
18. Additional Comments or Observations
19. Names, Signatures and Occupations of Persons who Investigated Accident
20. Witness Information

Joint Accident Investigation Form

Agency		phone Number	Location		Date of Report	
Last Name of Injured (or ill) Person			First Name		File No#	
Years of Service		Time on Present Job	Occupation		Hours Worked in Previous 24 Hour Period	
Accident Category (check)	Injury or illness	Equipment Malfunction	Motor Vehicle	Property Damage	Fire	Other (specify)
Severity of Injury or Illness (check)			No Injury or First Aid Only	Medical Treatment	Time Loss	Fatal
Nature of Injury or Illness						
Description Of Accident or Employee's Account of Occupational Disease (eg. RSI) (use separate sheet if necessary)						
Were written safe work procedures established and Available?			Where they adequate?		Were these safe work procedures used in Training?	
Yes No N/A			Yes No N/A		Yes No N/A	
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS						

Corrective Measures Taken and/or Recommended

Corrective Action Referred to: _____ Date to be completed by: ____/____/____

Additional Comments or Observations. Where applicable give details of makes & models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

Name(s) & occupations of person(s) who investigated accident:

Print Name & Occupation _____ _____
Phone

Print Name & Occupation _____ _____
Phone

Signature of Workers' Representative _____
Date

Signature of Employer Representative _____
Date

Name(s) of Witness(s) (include phone number)