Purpose and Scope

A. The purpose of this procedure is to:

1- Provide guidance for the timely reporting of work related injuries, illness, and incidents.

2- Prevent incidents from recurring.

B. This policy applies to all employees of American Labor Pool Inc (ALP).

Requirements

A. Reporting

1- All incidents shall be reported <u>IMMEDIATELY</u> and no later than <u>PRIOR TO THE END OF YOUR SHIFT</u>.

2- Incidents shall be reported to:

a. Their appropriate level of on-site management (e.g. Supervisor), and

b. The Branch Manager

3- A reportable incident may include, but is not limited to the following:

a. An injury to any ALP employee, subcontractor, client representative, or private citizen, even if the injury does not require medical attention;

b. An injury to a member of the public occurring on a work site possibly resulting from a ALP activity or involving ALP's property, equipment, or resource;

c. Illness resulting from suspected chemical exposure;

d. Chronic or re-occurring conditions such as back pain or cumulative trauma disorders;

e. Fire, explosion, or flash;

f. Any vehicle accidents occurring on site, while traveling to or from client locations, or that involve any company-owned or company-leased vehicle;

g. Property damage resulting from any COMPANY activity;

h. Structural collapse or potential structural hazards;

i. Unexpected release or imminent release of a hazardous material;

j. Unexpected chemical exposures to workers or the public;

k. A safety related complaint from the public regarding ALP activities; or

l. Any other significant occurrence that could impact safety - WHEN IN DOUBT, FILL IT OUT.

B. Responsibilities/Actions

1- Employee

a. If necessary, suspend operations and secure and/or evacuate the area

b. Notify emergency services (911) as needed

c. Immediately (or as soon as practicable) notify personnel as stated in aforementioned section *(Requirements, A)*

d. Record all information pertaining to the incident (e.g. time, date, location, name and company of person(s) involved, description of event, and actions taken)

e. Complete and distribute Employee Incident Statement Form within 24 hours

f. Assist with incident investigation as directed by management

g. Implement corrective actions as directed by management

h. ***Do not*** discuss the incident with members of the news media or legal representatives (except ALP legal counsel or your personal legal advisor) unless directed to do so by management
i. ***Do not*** make statements pertaining to guilt, fault, or liability

2- Branch Manager
   a. Review circumstances of the incident with applicable employee(s)
   b. Complete and distribute Incident Report within 24 hours
   c. Have any witnesses to incident complete and return Witness Incident Form
   d. Review and verify that necessary corrective actions are identified and implemented
   e. Discuss with department or project staff the circumstances surrounding the incident and corrective actions taken

3- Risk Manager
   a. Assist with incident evaluation as applicable
   b. With management, identify cause(s) of incident and identify corrective actions needed to avoid recurrence
   c. Review injury/incident report for completeness and accuracy
   d. Determine OSHA recordability and maintain OSHA 300 log (as applicable)
   e. Report work-related injuries and illness to worker compensation carrier

C. Media Inquiries

1- All media reporters and related persons must be directed to a COMPANY Management Representative.

2- Only a designated company representative will speak to the media under all circumstances.

3- Under no circumstance, are employees allowed to speak to the media about anything related to the incident.

Documentation Summary

A. Incident Investigation Form

B. Employee Incident Statement Form

C. Witness Form

D. Medical Authorization Form

E. OSHA Forms (300, 300A, 301) – as applicable

1- http://www.dir.ca.gov/dosh/dosh_publications/RecKeepOverview.pdf

References

A. OSHA Fact Sheet

1- http://www.dir.ca.gov/dosh/etools/recordkeeping/CaStandard/CA1430029.htm?A=1430029b10

Incident Investigation Form

(this form shall be completed by the direct supervisor, foreman, or manager)

Incident Type: ❑ Injury ❑ Property ❑ First-Aid Only ❑ Information Only

Name:		Date of Incident:
Job Title:		Date Reported:
Department:		Time Occurred:
Age:	M / F ? :	Hours Worked Prior to Incident:
Other Party(ies) Involved (Y / N) ?:		Location of Injury:

Incident Information

Description of incident: (Include: tools or equipment in use, task being performed, etc.)

____

____

____

____

____

Describe in detail the type/extent of injury, including specific body part affected:

____

____

Was medical treatment sought *(circle one)*? Yes No, treatment was declined at time of incident

If yes, from whom? ____

( ) On-site ( ) Healthcare Clinic ( ) Emergency Room/Hospital ( ) Doctor

Has Injured Been Treated for this Condition Before (if yes, please describe)?:____________________

____

Summary

Your recommendations to prevent this from occurring again? (Please be specific)

____

____

Employee Signature:	Date:
COMPANY Representative Signature:	Date:

Employee Incident Statement Form

(this form shall be completed by the employee only)

Name:		Date of Incident:
Job Title:		Date Reported:
Department:		Time Occurred:
Age:	M / F ? :	Hours Worked Prior to Incident:
Other Party(ies) Involved (Y / N) ?:		Location of Injury:

INCIDENT INFORMATION

Please describe the incident in detail (include tools or equipment in use, task being performed, etc.)

____

____

____

____

____

Please describe, in detail, the type/extent of injury, including specific body part affected:

____

____

Was medical treatment sought *(circle one)*? Yes No, treatment was declined at time of incident

If yes, from whom? ____

( ) On-site ( ) Healthcare Clinic ( ) Emergency Room/Hospital ( ) Doctor

Have you been treated for this condition before?: Yes No

If YES, please describe briefly:

COMPANY will make available Temporary Modified Duty when possible. If you have been released by your physician to return to work on Temporary Modified Duty or without restriction, you are required to inform Human Resources.

I understand that providing false and misleading information to COMPANY or COMPANY's insurance company is subject to criminal prosecution.

Employee Signature:	Date:
COMPANY Representative Signature:	Date:

Witness Form

Name: ______________________________________ Phone Number: ________________________

Address: ____

Did you see the incident?: YES / NO Date: ______________ Time : __________ AM / PM

Where did it happen?: ____

____

Where were you?: ____

____

Was anyone injured? If so, whom?: ____

____

Describe exactly what happened? ____

____

____

____

Do you have any relation to anyone involved?: YES / NO

If YES, whom?: ____

Name(s) of other possible witnesses?: ____

____

Witness Signature:	Date:
COMPANY Representative Signature:	Date:

Medical Authorization

I, the undersigned, authorize any medical care provider who has treated me, or any hospital to which I have been admitted, to furnish to any authorized representative of COMPANY any and all information which may be requested regarding my physical condition and treatment, and if necessary, to allow them or any physician appointed by them to examine any X-rays or records regarding my physical condition or treatment.

Authorized representatives may include:

- ALP
- ________________________________ *{insurance carrier}* ;
- ________________________________ *{additional party}* ; or
- any other agent or employee of the above stated parties by a hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment.

I understand that I have a right to receive benefits for compensable injuries whether or not I sign this form. My signature is voluntary and is for the purpose of improving communications between my doctor and ALP or its agents.

____

(employee print)

________________________________ ________________

(employee signature) *(date)*

________________________________ ________________

(ALP *representative signature)* *(date)*