EMSL
Electric Motor Service Limited

SAFETY MANUAL

INCIDENT AND OCCUPATIONAL ILLNESS REPORTING AND INVESTIGATION POLICY

POLICY

It is the requirement of Electric Motor Service Limited for all employees to report all hazards, unsafe acts, unsafe conditions, incidents, and occupational illnesses regardless of their severity to their supervisor or manager within 24 hours of the incident. The company also requires all work refusals to be reported to their immediate supervisor or manager.

Incidents are defined as follows:

Near Miss	Nothing happens but, given a different set of circumstances, injuries or property damage could result
First Aid	Employee seeks treatment from a physician. No time lost, employee returns back to work for the next scheduled shift
Lost Time	Employee seeks treatment from a physician and requires time away from work for a period of time
Property Damage	Any damage to property
Environmental Impact	Any damage to the environment, such as a chemical spill
Vehicle Accident	For any work-related motor-vehicle accidents
Refusal of Dangerous Work	A worker may refuse to work or do particular work at a work site if the worker believes on reasonable grounds that there is dangerous work at the work site or the work constitutes a danger to the worker's health and safety or to the health and safety of another person
Occupational Illness	A condition which results from exposure in a workplace to a physical, chemical or biological agent to the extent that the normal physiological mechanisms are affected and the health of the worker is impaired.

The employee's direct supervisor shall ensure that all incidents are recorded and reported to the Workers' Compensation Board and Occupational Health and Safety as required by legislation such as a worker being admitted to a hospital and incidents with the potential to cause serious injury.

Employees are required by law to submit the employer report of injury WCB Report within 72 hours after becoming aware of an injury or illness. A WCB Report must be submitted if the accident results in or is likely to result in:

- Lost time or the need to temporarily or permanently modify work beyond the date of the accident.
- The death or permanent disability of an employee (such as amputation, hearing loss).
- A disabling or potentially disabling condition caused by occupational exposure or activity (such as poisoning, infection, chiropractic)
- Incurring medical expenses (such as dental treatment, eyeglass repair or replacement, prescription medication)

Employers may report using one of three methods: report online by using myWCB, submit a one-time injury report or report by fax.

The purpose of such investigations is to determine the root cause of the incident so appropriate action can be taken to prevent reoccurrence. It is important to remember the focus of the investigation is not to lay or assess blame, but rather to determine the cause of the incident and identify short term and long term corrective actions.

All Managers and Supervisors will be required to complete formal investigation training. This training shall include a casual analysis model and explanation of how "root cause" is determined.

Immediate Supervisors shall be responsible for conducting the initial investigation for all incidents that involve an injury requiring medical aid or property damage within 24 hours and submitting reports and recommendations to the management team. Managers will determine the appropriate corrective actions and together with the management team and workers implement corrective action(s) in a timely manner.

PROCEDURE

Step 1: Reporting and Caring for the Injured

- See Man Down procedure and assign investigation team (Manager, immediate Supervisor, Health and Safety Committee member).

Step 2: Conduct Investigation

- The investigation should commence as soon as possible following the incident. It is important that the scene be controlled immediately to prevent possible evidence from being disturbed or removed and to identify possible witnesses as soon as possible
- Assess the scene and document everything about the scene that seems pertinent. This may include:
    - Environmental conditions (condition of ground, weather if outside, lighting, wet floor signs present, road conditions, crowding, air quality)
    - Hazards in area (electrical, mechanical, physical, chemical)
    - Hazards specific to affected individual (carrying heavy load, inappropriate action, medical condition, footwear)
    - Witnesses in area
- Conduct interviews – identify witnesses and have them describe how the incident occurred. Ask the questions: who, what, when, where, why and how.
- Determine contributing factors – determine what factors contributed to the incident. This may include wet conditions, faulty equipment, human error, lack of training, fatigue, etc.
- Complete investigation form – report findings and determine corrective actions needed to prevent reoccurrence.

- Review investigation in monthly health and safety meeting - if further recommendations are suggested, it will be added to the investigation form.
- Review of investigation by senior level – Senior Management will review all forms and determine if recommendations for corrective actions are appropriate or whether additional actions need to be considered.

Step 3: Communicate Results

- Once the investigation has been completed and reviewed by all levels, the results of the investigation should be communicated to all staff in a Safety Meeting. The Safety Meeting will have a brief description of the incident and more importantly, what actions the company will be taking to prevent similar incidents in the future
- Managers of all areas are responsible for communicating the information at the Safety Meeting and ensuring all employees within their area sign the meeting minutes

Step 4: Review and Revise

- Once actions have been decided upon, a corrective action report will be developed and monitored until completed.
- Once implemented, the corrective action will continue to be evaluated to ensure the effectiveness of the corrective action.

President _____ Date: Nov 5/19

CFO _____ Date: July 4/19

INCIDENT INVESTIGATION REPORT		
Date Reported:	Time Reported:	Exact Location of Incident:
Occurrence Date:	Occurrence Time: OR Condition Developed Over Time: Yes ( ) No ( )	SWPP/JHA: Yes ( ) No ( ) Copy Attached?: Yes ( ) No ( )
Lead Investigator:		
Worker:	Supervisor:	Attending Safety Representative:
Date of Hire:	Occupation/Job at Time of Incident:	Length of Time in Occupation/Job: _____ Years _____ Months _____ Days
Type of Employment: Full Time ( ) Part Time ( ) Seasonal ( ) Contractor ( )		Salary ( ) Hourly ( )
Lost Time Claim?: Yes ( ) No ( ) If Yes, WCB Claim Attached?: Yes ( ) No ( ) Modified Duties?: Yes ( ) No ( )		
Injury/Illness ( ) Fatality ( ) Lost Time Incident ( ) Medical Aid ( ) First Aid ( )		
Part of Body Injured: (provide a detailed description and specify left or right)		
Has the Injured Worker had a Previous Similar Injury or Disability?: Yes ( ) No ( ) Describe in Detail:		
Name of First Aid Attendant:	Injury Recorded in First Aid Log: Yes ( ) No ( ) Copy Attached?: Yes ( ) No ( )	Type of First Aid Administered:
Clinic/Hospital Sent To:	Attending Physician/Paramedic:	Attending Police Officer:
PROPERTY DAMAGE		
Property Damage:	Estimated Cost of Damage:	
Description of Property Damage:		

IMMEDIATE EFFECTS TO SAFETY OF WORKERS AND PRODUCTION
Nature of Occurrence:
Equipment and Materials Involved:

Evaluation of Immediate Risk Potential: Major ( ) Serious ( ) Minor ( )	Probability of Recurrence: Frequent ( ) Occasional ( ) Rare ( )

Immediate Corrective Action Taken:
WITNESS INFORMATION

Worker/Contractor:	Contact Details:	Witness Statement Provided: Yes ( ) No ( ) Copy Attached?: Yes ( ) No ( )

INCIDENT INFORMATION
Type of Occurrence: Struck By ( ) Struck Against ( ) Fall to Lower Level ( ) Caught In ( ) Caught On ( ) Caught Between ( ) Over Exertion ( ) Over Stress ( ) Exposure ( ) Other: _____
Contact With: Cold ( ) Heat ( ) Electricity ( ) Noise ( ) Pressure ( ) Radiation ( ) Caustic Chemical: _____ Toxic Chemical: _____ Other: _____
Describe in detail the SEQUENCE OF EVENTS leading up to the incident. Where incident occurred; what the employee was doing at the time; the employee's mental state; the size, type and weight of equipment or materials involved; weather conditions. Diagrams/Photos Attached?: Yes ( ) No ( )

Identify all the UNSAFE ACTS which contributed to the incident:		
( ) Operating Without Authority	( ) Horseplay	( ) Hazardous Personal Attire
( ) Unsafe Loading/Unloading	( ) Inadequate Lighting	( ) Servicing Operating Equipment
( ) Unsafe Mixing/Combining	( ) Horseplay – Distracting	( ) Using Defective Tools
( ) Failure to Wear Proper PPE	( ) Horseplay – Teasing	( ) Using Defective Equipment
( ) Failure to Warn Properly	( ) Horseplay – Harassment	( ) Working on Moving Equipment
( ) Failure to Secure Properly	( ) Horseplay – Willful Misconduct	( ) Improper Lifting
( ) Unsafe Position or Posture	( ) Making Safety Device Inoperable	( ) Other: _____
( ) Under the Influence of Alcohol and/or Drugs (either Illicit or Prescription)		

Identify all UNSAFE CONDITIONS which contributed to the incident:		
( ) Inadequate Guards/Barriers	( ) Extreme Temperature(s)	( ) Unsafe Job Design
( ) Improper or Inadequate PPE	( ) Inadequate Lighting	( ) Extreme Weather Conditions
( ) Defective Tools or Equipment	( ) Hazardous Environmental Conditions	( ) Unsafe Mobile Equipment
( ) Defective Materials	( ) Gases ( ) Dusts ( ) Smoke	( ) Hazardous Procedure
( ) Congested Work Area	( ) Fumes ( ) Vapors	( ) Noise Exposure
( ) Inadequate Warning Systems	( ) Fire Hazard	( ) Radiation Exposure
( ) Poor Housekeeping	( ) Explosion Hazard	( ) Other: _____

Identify all INDIRECT CAUSES which contributed to the incident:	
PERSONAL FACTORS	JOB FACTORS
( ) Inadequate Physical Capability	( ) Inadequate Leadership or Supervision
( ) Inadequate Mental Capability	( ) Inadequate Engineering Controls
( ) Physical Stress	( ) Inadequate Purchasing
( ) Mental Stress	( ) Inadequate Maintenance (Scheduled/Preventative)
( ) Lack of Knowledge	( ) Inadequate Tools or Equipment
( ) Lack of Skill	( ) Inadequate Work Standards
( ) Improper Motivation	( ) Wear and Tear
	( ) Abuse or Misuse of Equipment

ROOT CAUSES (INADEQUATE PROGRAM STANDARDS)	
( ) Management Commitment & Administration	( ) Emergency Preparedness and Response

( ) Leadership Training	( ) Company Safety Rules and Work Permitting
( ) Planned Inspections	( ) Worker Knowledge and Skill Training
( ) Preventative Maintenance	( ) Personal Protective Equipment (PPE)
( ) Hazard Identification	( ) Personal or Group Communications
( ) Safe Work Practices and/or Procedures	( ) Hygiene and Sanitation
( ) Inadequate Previous Incident Investigation	( ) Hiring and Placement Standards
( ) Off-the-Job Safety Promotion	( ) Purchasing Controls
	( ) Other: _____

PREVENTION

( ) Training/Retraining of Involved Worker(s)	( ) Improve Safety Inspection Process
( ) Job Procedure/Design Changes	( ) Reassignment of Involved Worker
( ) Equipment Repair or Replacement	( ) Liaison with Manufacture of Equipment/Tool
( ) Perform In-Depth Hazard Identification and Analysis	( ) Facilities Layout Review and Redesign
( ) Improved Hazard Controls (Engineered/Admin/PPE)	( ) Installation of Safety Guards/Barriers
( ) Supervisory Communication	( ) Other: _____

Describe Action(s) Taken to Prevent Reoccurrence (Short Term and Long Term)

Signed by Safety Manager:		Date:
Signed by Worker:		Date:
Signed by Manager or Supervisor:		Date:
Signed by H&S Rep:		Date:
Reported to OH&S?: Y: ( ) N: ( ) *INCIDENTS WITH POTENTIAL TO CAUSE HARM OR SERIOUS DAMAGE MUST BE REPORTED*	Copy of Report Provided to Worker: Y: ( ) N: ( )	
Follow Up To Confirm Action Items Were Completed	Date of Follow Up:	Signature of Person that Followed Up:
INVESTIGATION CLOSED DATE:		

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VENDOR INCIDENT INVESTIGATION REPORT

INCIDENT TYPE: ☐ INJURY/ILLNESS ☐ PROPERTY DAMAGE ☐ FIRE ☐ OTHER
☐ VEHICLE COLLISION ☐ MAJOR POTENTIAL ☐ SPILL

INCIDENT DATE: *(mm/dd/yy)*	TIME:
AREA/DEPARTMENT:	SPECIFIC LOCATION:

INCIDENT:

VENDOR EXPLANATION *(supervisor to fill out)*

UNDERLYING CAUSE(S):

CORRECTIVE ACTIONS (IMMEDIATE/INTERM/FINAL):

POSITION:	DATE *(mm/dd/yy)*:
SIGNATURE:	

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VENDOR INCIDENT INVESTIGATION REPORT

NAME OF TECHNICIAN:
COMPANY:
SUPERVISOR:
SUPERVISOR PHONE/EMAIL:

WHEN COMPLETING THIS STATEMENT, BE SURE TO INCLUDE ALL EVENTS AND FACTORS THAT LED TO THIS ACCIDENT/INCIDENT/LOSS, INCLUDING ACTIONS TAKEN DURING AND AFTER.
USE THE BACK OF THIS FORM FOR ANY ADDITIONAL INFORMATION.
ATTACH ALL ORIGINAL WITNESS STATEMENTS TO THE ACCIDENT/INCIDENT/LOSS REPORT.
PLEASE PRINT CLEARLY.

PLEASE PROVIDE A STATEMENT FOR INITIAL REPAIRS TO THE CRANE & FOR THE FOLLOW UP REPAIRS AFTER THE INCIDENT
(USE MULTIPLE SHEETS IF NECESSARY OR IF DIFFERENT TECHNICIANS PERFORMED REPAIRS)
INCLUDE DATES AND APPROXIMATE TIMES IF POSSIBLE.

STATEMENT:

SIGNATURE OF TECHNICIAN:		SIGNATURE OF SUPERVISOR:	

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ACCIDENT/INCIDENT/LOSS WITNESS STATEMENT

NAME:	COMPANY:
CELL PHONE:	DATE:
OTHER PHONE:	TIME:
LOCATION OF INCIDENT:	
BRIEF DESCRIPTION OF INCIDENT:	

WHEN COMPLETING THIS STATEMENT, BE SURE TO INCLUDE ALL EVENTS AND FACTORS THAT LED TO THIS ACCIDENT/INCIDENT/LOSS, INCLUDING ACTIONS TAKEN DURING AND AFTER.
USE THE BACK OF THIS FORM FOR ANY ADDITIONAL INFORMATION.
ATTACH ALL ORIGINAL WITNESS STATEMENTS TO THE ACCIDENT/INCIDENT/LOSS REPORT.
PLEASE PRINT CLEARLY.

STATEMENT:

SIGNATURE:

FILE #	DATE RECEIVED:	JOB #
RECEIVED BY:		

POLICY

Electric Motor Service Limited is committed to doing everything we can to achieve a successful recovery and return to work for our injured employees. Our disability management program is designed to help return employees to work safely and at the earliest opportunity, using appropriate modified work alternatives when needed. Under no circumstances should any EMSL employees, supervisors or managers offer payment as compensation or treat the injured worker inappropriately causing the worker to decline submission to WCB. Failure to comply will result in immediate termination.

PROCEDURE

- Report injury to supervisor
- Supervisor to notify the Safety Manager or Safety Administrator
- Incident Investigation is to be completed (see Incident Investigation Policy & Procedure)
- Safety Manager or Safety Administrator to provide necessary paperwork to employee
- Supervisor must fill out the PHYSICAL DEMANDS ANALYSIS FORM BEFORE employee visits a treating physician, UNLESS the employee would prefer to choose to visit an OIS clinic.
- Employee to visit medical professional (doctor of their choice, have the option to go to OIS clinic). If employee chooses to not go to an OIS clinic, the FITNESS FOR WORK FORM must be filled out in complete by the treating physician. Supervisor is to assist employee to clinic or alternately send designate with employee.
- Supervisor to ensure WCB paperwork is complete and provided to the Safety Administrator
- Employee to provide return to work details to supervisor
- Supervisor to present OFFER OF MODIFIED WORK FORM to employee
- Supervisor to monitor employee and return to work status
- Safety Administrator to ensure all forms are sent to WCB

President _____ Date: May 1/19

CFO _____ Date: April 29/19

NOTICE TO INJURED EMPLOYEE

You are valuable to Electric Motor Service Limited and we are committed to do everything we can to work with you to achieve a successful recovery and return to work.

Our disability management program is designed to help you return to work safely and at the earliest opportunity using modified work alternatives if needed.

Included with this package are the following forms:

1. Physical Demands Analysis Form – to be completed by your Supervisor if you choose to not visit an OIS Clinic
2. Fitness for Work Form – to be completed by the treating physician if you choose to not visit an OIS Clinic
3. Offer of Modified Work Form – to be completed by your Supervisor after you return from the treating physician

Forms not included in this package are the WCB Employee report (to be completed by the employee) as well as the Incident Investigation Report (to be completed by the employee and supervisor)

THESE FORMS ARE VERY IMPORTANT IN PLANNING FOR YOUR RETURN TO WORK AND MUST BE COMPLETED IN FULL.

If you must be off work, please contact your Supervisor or Manager daily as well as after seeing your treating physician. Should it be necessary to replace you on modified duties to accommodate an early return to work, we will continue your regular job rate of pay.

Please contact your Supervisor, Manager, Safety Manager of Safety Admin if you have any questions or if there is anything further we can do to assist you.

Signed by Worker:		Copy Provided?: Y: ( ) N: ( )
Signed by Manager or Supervisor:		

PHYSICAL DEMANDS ANALYSIS		
Claim Number:	Worker:	Supervisor:
Hours Per Shift	Shifts Per Week:	Supervisor Contact Number:

Manual Handling Tasks	Description of Objects Handled [weight/force (lb)]	Frequency of Workday/Shift				
		Not Required	Rare 1-5%	Occasional 6-33%	Frequent 34-66%	Constant 67-100%
Low Level Lifting						
Waist Level Lifting						
Above Shoulder Lifting						
Front Carry						
Side Carry						
houlder Carry						
Pushing (Stationary and Walking)						
Pulling (Stationary and Walking)						
Positional Tasks	**Description of Activity Completed**	**FREQUENCY OF WORKDAY/SHIFT**				
Sitting/Driving (type of seat/chair)						
Forward Bending						
Trunk Rotation						
Standing						
Walking-Outdoors (terrain/distance)						
Walking-Indoors (surface/distance)						
Climbing (stairs/ladders/stools/equipment)						
Low Level Activity (kneeling/squatting/crouching)						
Above Shoulder Level Reaching						
elow Shoulder Level Reaching						

Hand Use Dominant						
Hand Use Non Dominant						
Forceful Gripping Dominant						
Forceful Gripping Non Dominant						
Environmental Factors (Indoor/Outdoor)						

List Heaviest and Most Frequently Handled Materials		**List Most Frequently Handled Tools and Equipment**	

Primary Job Duties	

Separate the Above Primary Job Duties into Specific Tasks Within Each Strength Level

Limited: Exerting up to 11 lb
Light: Exerting up to 22 lb
Medium: Exerting up to 44 lb
Heavy: Exerting over 44 lb

Alternate Job Duties:		
Signed by Worker:		Copy Provided?: Y: ( ) N: ( )
Signed by Manager or Supervisor:		

NOTICE TO HEALTH CARE PROVIDER - FITNESS FOR WORK

Company Contact:	Phone:	Fax:

Electric Motor Service Limited is committed to doing everything we can to achieve a successful recovery and return to work for our injured employees. Our disability management program is designed to help them return to work safely and at the earliest opportunity, using appropriate modified work alternatives when needed.

Please complete the below fitness for work section at the time of treatment and fax it to the above number, or have our employee return it. A reporting fee will be paid and will be reimbursed to the employee.

Authorization to Release Information (to be completed by the injured employee)

Injury: Injury Date:

I hereby authorize my treating health care provider to release information related to my fitness for work.

Employee Name: Date:

Employee Signature:

Fitness for Work (to be completed by treating health care provider)

Examination Date: Injury:

Current capabilities: please make a selection below as they rate to the injury.

Sitting	☐ Able	☐ Unable	☐ Limited to ___ hours per shift	Standing	☐ Able	☐ Unable	☐ Limited to ___ hours per s
Walking	☐ Able	☐ Unable	☐ Limited to ___ hours per shift	Bending	☐ Able	☐ Unable	☐ Limited
Twisting	☐ Able	☐ Unable	☐ Limited	Kneeling/Squatting	☐ Able	☐ Unable	☐ Limited
Climbing	☐ Able	☐ Unable	☐ Limited	Lifting	☐ Able	☐ Unable	☐ Limited to ___ hours per shift
Pushing/ Pulling	☐ Able	☐ Unable	☐ Limited	Overhead Reaching	☐ Able	☐ Unable	☐ Limited
Driving	☐ Able	☐ Unable	☐ Limited to ___ hours per shift	Number of hours patient is capable of working per day:			

Reasons why the patient cannot work: ☐ hospitalized ☐ self-reported pain ☐ opioids/medication side effects

Additional Comments/Special Considerations:

Estimated date fit for regular work:	Healthcare Provider's Name:

Healthcare Provider's Signature:

Clinic Address:

OFFER OF MODIFIED WORK		
In keeping with our policy to consider alternate suitable employment for an employee unable to perform their regular work due to injury, we are offering the following modified work placement. It is expected you will only perform the duties outlined below. Your supervisor will monitor your progress and meet with you weekly to adjust your duties and/or length of placement as required based on your ability and relevant medical information. If you have any difficulties performing the modified work, please notify your supervisor immediately.		
The modified work position is:		
The duties you are required to perform are as follows:		
Hours of Work:	Days of Work:	
The duration of the modified work placement will be from _____ to _____		
Offer Accepted ❑	Offer Rejected ❑	
Signed by Worker:		Copy Provided?: Y: ( ) N: ( )
Signed by Manager or Supervisor:		
WCB Case Number:		

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SAFETY MANUAL

RETURN TO WORK DISCUSSION/INTERVIEW FORM

PURPOSE: This Return to Work Discussion/Interview Form is designed as a guide and prompt for good practice for managers and supervisors when meeting with employees on return to work from sickness absence. You may complete some or all of this form, depending on the circumstances.

Name:
Location:

Absence Details

First day off work:	Date of return to work:
Day(s) absent:	
Did the employee follow correct absence reporting procedures: ☐ YES ☐ NO	
Doctor's note received: ☐ YES ☐ NO (if not, why?):	
COVID-19 negative diagnosis or clearance from Health Canada: ☐ YES ☐ NO	
Reason for absence:	
Is the employee fit to resume normal duties: ☐ YES ☐ NO	

Return to Work Interview

ate of interview:
Currently self-monitoring for symptoms: ☐ YES ☐ NO
Are you feeling any symptoms of illness:
Are you able to work normal hours and duties:
What was the possible cause of your sickness absence and what action have you taken to avoid any future occurrence:
Was a doctor or other medical practitioner consulted: ☐ YES ☐ NO
Are you on any medication which may affect your performance: ☐ YES ☐ NO

Next Steps to Prevent Further Absences

Summary of action points (if applicable) agreed and any other comments:
Review date for agreed actions:

Employee signature:	Date:
Manager signature:	Date:

Location: ☐ 8835 60 Avenue ☐ 8315 Davies Road ☐ Calgary ☐ Fort McMurray ☐ Office ☐ Shop		
Employee Name:	Date Reported:	
Description of Near Miss/Hazardous Condition including location:		
What could have happened if not corrected?		
List what immediate action you have taken to eliminate or minimize the hazardous condition(s):		
Make some recommendations on how to further eliminate or minimize the hazardous condition(s):		
Signed by Worker:		
Department Supervisor's Comments:		
Supervisor's Signature		Date:
Date corrective action to be completed by: Date: Person:	Actual date corrective action completed: Date: Person:	
Safety Manager Signature:		Date:
Safety Manager Comments:		
SCAR Required?	☐ Yes #	☐ No

General Guidance Following a Fatality Accident

Dealing with the death of one or more employees is a traumatic event, and there are a number of things to consider after the initial emergency response has begun. The following is a guide on what is required by law; it also provides other information to assist through this difficult situation. This procedure assumes that an emergency medical response has been provided and that emergency crews and law enforcement have been alerted to the scene.

Controller's Responsibilities:

1. Notify the company executives/owners.
2. Determine who within the organization is "in charge" of the accident scene and who will serve as the official company contact for information.
3. Direct the designate in charge to complete a thorough incident investigation report including photographs of the scene.
4. Notify OH&S as soon as possible.
5. Determine who will notify immediate family members and confirm that it will be done with tact and good judgement
6. Keep in contact with WCB & Blue Cross.
7. Remind employees, supervisors & managers of Blue Cross counselling services.
8. Prepare a plan to notify all management and employees about the situation.
9. Prepare for the possibility of media inquiries. Designate an authorized person to speak to the media and make sure all employees know that this is the only person authorized to provide statements to the media.
10. Stay in contact with the family members of the accident victim. Offer counseling assistance and help, explain any benefits that may be provided. Consider sending condolence cards, flowers, or assisting with meals to help them through the difficult first few days).

Shop Supervisor and All Manager's Responsibilities:

1. Preserve the accident scene and all pertinent physical evidence or until OH&S or designated law enforcement has completed their investigation.
2. Participate in incident investigation.
3. Collect names and contact information of all witnesses including fellow employees, management or the general public. Consider releasing workers to go home after they have provided their statement. Be sensitive to the emotional impact that this accident may have on a witness.

4. Remind employees of Blue Cross counselling services.
5. Continue to be watchful of employees for signs that they may need counseling assistance.

Worker's Responsibilities:

1. Provide a witness statement if required.

Safety Representative's Responsibilities (In Addition to Worker's Responsibilities):

1. Complete necessary WCB paperwork.

Board Chairman _____ Date: Sept 19/19

ELECTRIC MOTOR SERVICE LIMITED ACCIDENT REPORT ENVELOPE

Procedure To Be Followed When A Motor Vehicle Accident Occurs

1) Exchange information with the driver of the other vehicle. Get and give:

   - Name of driver
   - Driver's license number
   - Insurance policy number
   - Telephone number(s)
   - Name of the vehicle's registered owner
   - Vehicle license plate number

2) Contact the local police and complete the required police accident report anytime combined damage on all vehicles exceeds $1000.00 and/or possible bodily injury.

3) Get appropriate required assistance concerning injuries (if any occurred), towing the vehicle, etc.

4) Take some pictures of the vehicles and the other driver and party members, as soon as possible, using your camera phone or ask a witness or passerby. Have pictures emailed to dave.ash@emsl.ca.

5) Ask if the other driver or party can get two estimates for repair.

6) Get a readable copy of the police accident report.

7) Complete the enclosed Company accident report.

8) Fax the police and Company accident reports to Electric Motor Service Limited: Attention Dave Ash, within one business day of the accident.

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ELECTRIC MOTOR SERVICE LIMITED ACCIDENT REPORT ENVELOPE

Automobile Accident Report

To: Electric Motor Service Limited
8835 – 60 Avenue
Edmonton, Alberta
T6E 6L9

Date: _____

Branch #: _____

Attn: Dave Ash
Phone: (780) 496 – 9300
Fax: (780) 496 - 7629

From: _____

Please complete the following sections of the accompanying AUTOMOBILE ACCIDENT REPORT. (Some section titles appear on the left side of the REPORT in the shaded column.)

- VEHICLE section
- DRIVER section
- DAMAGE TO PROPERTY OF OTHERS section
- PERSONS INJURED section
- WITNESSES section
- DESCRIPTION OF ACCIDENT section

The Driver must date and sign the second page of the REPORT.

ELECTRIC MOTOR SERVICE LIMITED ACCIDENT REPORT ENVELOPE

Accident Report Form

INSURER			AGENT OR BROKER		CLAIM NUMBER
POLICY HOLDER	NAME OF INSURED		RESIDENCE PHONE	BUSINESS PHONE	POLICY NUMBER
	HOME ADDRESS		POSTAL CODE	BUSINESS ADDRESS	POSTAL CODE
VEHICLE	REGISTERED OWNER			ADDRESS	
	ACTUAL OWNER			ADDRESS	
	MAKE OF VEHICLE	YEAR	MODEL	SERIAL NUMBER	LICENSE NO. & PROVINCE
	MILEAGE	DESCRIBER DAMAGE			ESTIMATE OF DAMAGE
DRIVER	NAME OF DRIVER		AGE	STATE ANY PHYSICAL DISABILITIES	HOW LONG DRIVING
	ADDRESS			BUSINESS ADDRESS	
	RESIDENCE PHONE NUMBER			BUSINESS PHONE NUMBER	
	DRIVER'S LICENSE NO.		PREVIOUS ACCIDENTS OR CONVICTIONS		
	DATE OF ACCIDENT		TIME	DAYLIGHT, DUSK, OR DARK	LOCATION OF ACCIDENT
	PURPOSE VEHICLE USED FOR AT TIME OF ACCIDENT			WEATHER CONDITIONS	ROAD CONDITIONS
	YOUR SPEED		DIRECTION	OTHER'S SPEED	DIRECTION
	POLICE INVESTIGATION BY			CHARGES	
	HAD YOU TAKEN ANY ALCOHOLIC BEVERAGES OR DRUGS PRIOR TO THE ACCIDENT		YES NO	WHO WAS RESPONSIBLE FOR THE ACCIDENT - REASON	
DAMAGE TO PROPERTY OF OTHERS	NAME		PHONE	NAME	PHONE
	ADDRESS			ADDRESS	
	YEAR & MAKE OF VEHICLE		LICENSE NO.	YEAR & MAKE OF VEHICLE	LICENSE NO.
	NAME OF INSURER		POLICY NO.	NAME OF INSURER	POLICY NO.
	DESCRIPTION OF DAMAGE			DESCRIPTION OF DAMAGE	
	WHERE VEHICLE CAN BE INSPECTED			WHERE VEHICLE CAN BE INSPECTED	
	NAME OF DRIVER		PHONE	NAME OF DRIVER	PHONE
	ADDRESS			ADDRESS	

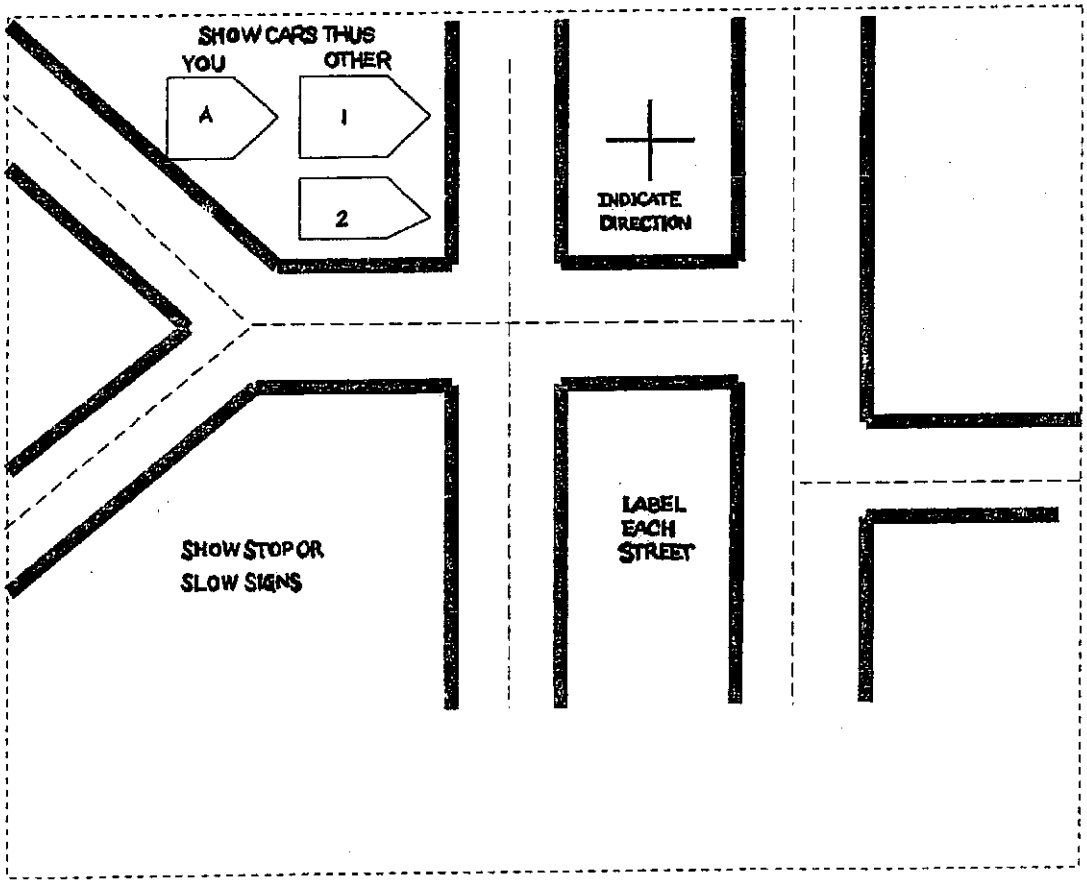
PERSONS INJURED	NAME	AGE	ADDRESS	PHONE	NATURE OF INJURIES	HOSPITAL

DETAILS OF ACCIDENT

WITNESSES	NAME	NAME	NAME
	ADDRESS	ADDRESS	ADDRESS
	PHONE NO.	PHONE NO.	PHONE NO.
	IN WHICH CAR? o YOUR CAR o OTHER CAR# 1 o OTHER CAR# 2 o OTHER	**IN WHICH CAR?** o YOUR CAR o OTHER CAR# 1 o OTHER CAR# 2 o OTHER	**IN WHICH CAR?** o YOUR CAR o OTHER CAR# 1 o OTHER CAR# 2 o OTHER

DESCRIPTION OF ACCIDENT

Illustrate the position of cars at the time of collision. Show Skid marks.
If any street is more than two lane o sir one way please indicate.



DESCRIBE WHAT HAPPENED

DATE	SIGNATURE OF DRIVER

TO BE COMPLETED BY POLICY HOLDER

WHO IS THE PRINCIPAL DRIVER OF YOUR VEHICLE?	WHAT IS THE DRIVER'S RELATIONSHIP TO YOU?
WAS THE VEHICLE BEING USED WITH YOUR CONSENT?	LIEN OR MORTGAGE VEHICLE TO:
DATE	SIGNATURE OF POLICY HOLDER