PURPOSE

To establish the recordkeeping process for work-related fatalities, injuries and illnesses by requiring immediate reporting and treatment followed with worker compensation claims if needed and ensuring the quality of written documentation. This will help develop an accurate understanding of the primary and secondary causes of an accident with injury and/or illness and the corrective measures needed.

SCOPE

This procedure applies to all operations within Midland Engineering Co., Inc..

DEFINITIONS

Accident: An unintended occurrence that either caused or may have caused personal injury, property damage, or interference with production.

RESPONSIBILITY

Managers or supervisors will document and complete an accident or injury investigation in a written report (Accident & Injury/Illness Report) and distribute appropriately.

All employees of the company will be familiar with accident and injury/illness reporting procedures.

The company safety director will maintain a computer data base tracking all work-related fatalities, injuries, illnesses, accidents, investigations, and insurance loss runs to help in the development of trending and loss control directions.

ACCIDENT MANAGEMENT PROCEDURE

- <u>Report all accidents, regardless of the severity of the injury, to your manager or supervisor immediately.</u>
- When an accident occurs, first and foremost, check to see if the injured person needs medical attention that may be more than first aid. If immediate medical care is necessary dial 911 or the designated site phone number for emergency services.
- Once the injured person has been cared for, management or supervisory personnel must take any immediate actions necessary to prevent a similar type accident.
- In all accident and injury situations the Accident & Injury/Illness Report must be completed and signed (this includes first aid cases and near misses).
- If the Accident & Injury/Illness Report can't be completed before treatment, the paper work will be completed as soon as practical. In all other accident and injury instances the manager or supervisor must complete and sign the Accident & Injury/Illness Report.
- Midland Engineering Co., Inc. requires all injured employees to complete a post accident substance abuse test when receiving medical treatment. (Refer to the drug free workplace policy)
- Injuries on the road will be handled on a case-by-case basis. Regardless of where the individual receives treatment the supervisor or manager must complete the Accident & Injury/Illness Report.
- When the injured individual returns to work, he or she must turn in all paper work from the doctor and treatment facility to the manager or corresponding supervisor.
- The manager or supervisor must submit the Accident & Injury/Illness Report to the safety director.
- The safety director will review the Accident & Injury/Illness Form, treatment facility reports, doctor's evaluation, and any other paperwork and if applicable complete a formal accident investigation, as well as assist with the coordination of return to work if necessary.
- Based on the information gathered and reviewed by the safety director it may be applicable to complete a First Report of Injury for submittal of the claim to the insurance company.
- The safety director will determine if the injury/illness is recordable on the OSHA 300 Log. If the event is recordable it must be recorded within seven calendar days of receiving the information about the injury/illness occurring.
- This process shall take no longer than 24 hours.

SERIOUS INJURY OR DEATH

For accidents resulting in serious injury, care should be taken to make sure the injured party receives the proper help. Managers and supervisors must make arrangements to complete the Accident & Injury/Illness Form and conduct a formal accident investigation.

For accidents resulting in one or more fatalities or hospitalization of three or more employees, the local area OSHA office must be notified. This notification is made by a senior company representative and must be made within 48 hours after the occurrence of the accident. It can be made either orally (telephone) or faxed to the OSHA Area Director.

RECORDS & OSHA FORMS

All paper work resulting from a work-related fatality, injury or illness will be maintained in the corporate office and reviewed by management to conduct an accident analysis. A copy of any faxes or letters sent to OSHA shall remain on file in the office. Recordkeeping forms must be maintained for at least 5 years.

If the injury/illness is recordable on the OSHA 300 Log, it must be recorded within seven calendar days of receiving the information about the injury/illness occurring. The annual OSHA 300A Summary must be reviewed and signed by a Midland Engineering Co., Inc. official and a copy is to be posted in a place visible to employees. The annual summary must be posted no later than February 1st of the year following the year covered by the records and the posting kept in place until April 30th. The OSHA 300A Summary is not to be altered, defaced or covered by other material.

DESIGNATED PROVIDER

Midland Engineering Co., Inc. utilizes Methodist Hospitals as its designated occupational medical facility. There are several convenient locations throughout the Indianapolis metropolitan area if a medical facility is needed. Attached to this section is a map of these locations. Methodist will provide Midland Engineering Co., Inc. with all appropriate return to work & job restrictions for each injury.

ACCIDENT & INJURY/ILLNESS REPORT FORM

GENERAL INFORMATION

Date: _____

Project: _____ Project Number: _____ Supervisor: _____

Project Manager: _____ Person Completing Form: _____

This form must be completed by a manager, supervisor or foreman within a 24-hour period and turned into the corporate office. It is the corporate policy to conduct post accident substance abuse screening as part of all occupational medical treatment. Refusal may result in termination of employment.

INJURED/ILL PERSON

Name (first, middle, & last) _____

SS# or Employee ID Number _____ Age:____ Male___ Female___ Date of Injury: _____

Occupation: _____ Company Division: _____

ACCIDENT & INJURY/ILLNESS SPECIFICS

Is this a first aid case only? No __Yes __ If yes explain: _____

What is the injury? _____Part of the Body: _____

When did the injury occur? _____ Witness to the injury? _____

Where did the injury happen? _____

How did the injury happen? _____

_____

Any damage to equipment? No __Yes __ If yes explain: _____

INJURY/ILLNESS TREATMENT INFORMATION

Did the employee refuse treatment? No __Yes __ If yes explain: _____

Medical treatment authorized by: _____

Name of medical treatment facility: _____

Address of medical treatment facility: _____

Medical billing and paperwork sent to: _____

Has the physician assigned restricted work? No __Yes __ If yes explain: _____

Has the physician assigned days away from work? No __Yes __ If yes how many: _____

Signature of Person Completing Form: _____

ACCIDENT & INJURY/ILLNESS INVESTIGATION FORM

Accident Date:_____

First Aid or Recordable Injury?_____ Employee Name: _____

Time of Day: _____ Project Address:_____

Project Number: _____Sex: _____ Birth Date: _____ Injured Part of Body:_____

Occupation when injured: _____ Location of Injury:_____

What job was being done?_____

What step in job process was being done?_____

How often does injured perform this job?_____

How did the accident happen? (provide specific details)_____

_____

_____

What did the individual do or fail to do that contributed to this incident?_____

What did someone else do or fail to do that contributed to the incident?_____

What other conditions contributed to the incident?_____

Is there a written safety rule written concerning this job? Yes No Were they being followed? Yes No

Was the injured employee instructed on the rule? Yes No

When did the individual last attend a safety meeting? _____Topic? _____

Names of witnesses: _____ Witness Statement:_____

_____

What actions have been taken and/or do you plan to take to prevent reoccurrence of this or any similar injury?

_____

_____

What recommendations do you make? _____

_____

Supervisor/Foreman Signature: _____Date:_____

Superintendent Signature: _____Date:_____

Witness Signature: _____Date:_____

CHEMICAL SPILL / HAZARDOUS SUBSTANCE EVALUATION SHEET

Job Location:_____

Hazardous Substance Name: _____

Product Location: _____

D.O.T. Number: _____ UN Class Hazard:_____

CAS Number:_____ Flash Point: _____

Ignition Temperature:_____ Boiling Point: _____

Flammable Limit Range: _____ lower % _____ to upper % _____

Vapor Density:(air=1.0) _____

Specific Gravity: (water=1.0) _____ Water Solubility: _____

Extinguishing Agent: _____

PPE Required: _____

EPA Suit: _____ Foam Type: _____

Flash Suit Required: _____

Evacuation Distance: _____ Hot Zone Size: _____

Special Precautions: TLV=_____ ppm _____

NFPA Rating: Red_____ Blue_____ Yellow _____ White _____

Special Information/Precautions:_____

_____

Evaluation By: _____