

Reporting Accidents/Injuries Page 1 of 7 Date Deborah **ALL** Plant:

9/6/2011 Safety Area:



Personnel responsible:

All Giles Employees

Safety equipment:

Proper safety equipment for the area and/or situation.

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Summary:

This Procedure provides guidelines for reporting accidents/injuries. It is also important to note that reporting injuries is in the employee's best interest not only to prevent similar accidents/injuries but also in case of future complications related to workman's compensation.

Procedure:

- All accidents/injuries must be reported immediately to the Lead Operator and in turn to the Safety Department and Plant Manager. Accidents/injuries must be reported no matter how small.
- All accidents/injuries must be reported regardless of whether the accident resulted in an
- Depending on the accident/injury, First Aid may be provided by a Trained Emergency Response Team Member.
- If the injury requires medical attention, the employee must be taken to the Urgent Care Office, located at the hospital (828-452-8354). If Urgent Care is closed the employee should be seen at the Emergency Room at MedWest/ Haywood Regional Hospital (828-452-8110). 911 is always an option.
- When an accident or injury is reported, the Accident/Injury Report is to be filled out preferably by the area supervisor. The purpose of the report is to establish the root cause of the accident/injury and corrective actions to prevent similar accidents/injuries in the future. Near misses will also be included in the process.
- The completed Accident/Injury Report will be filed with the Safety Department. If the accident/injury involves a temporary employee, the temp agency will be notified.



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Author: Deborah
Plant: ALL
Area: Safety

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Accident / Injury Report

<u>Instructions</u>: Complete this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness*.)

| This is a report of a: ☐ Death ☐ Lost Time ☐ I | Medical Treatment | Only | ☐ Near Miss |
|--|---|---------------------------|--|
| Date of incident: This report is made by: | This report is made by: ☐ Employee ☐ Supervisor ☐ Team ☐ Other | | |
| Step 1: Injured employee (complete this pa | art for each injured emplo | vee) | |
| Name: Address: Phone: Emergency Contact: | Sex: ☐ Male ☐ Female | ycc) | DOB: |
| Department: | Job title at time of incident: | | |
| Part of body affected: (shade all that apply) | Nature of injury: (most serious one) Abrasion, scrapes Amputation Broken bone Bruise Burn (heat) Concussion (to the head) Crushing Injury Cut, laceration, puncture Hernia Illness Sprain, strain Damage to a body system: Other | ☐ Re☐ Re☐ Sea☐ Te.☐ Month | employee works: gular full time gular part time asonal mporary hs with mployer: hs doing bb: |



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Step 2: Describe the incident Exact location of the incident: Exact time: What part of employee's workday? ☐ Entering or leaving work ☐ Doing normal work activities ☐ During meal period ☐ During break ☐ Working overtime ☐ Other_ Names of witnesses and statements (Contact Information if applicable): Attachments Written witness statements: Photographs: Maps / drawings: (#, Yes or No) What personal protective equipment was being used (if any)? Describe, step-by-step the events that led up to the accident/injury. Include names of any machines, parts, objects, tools, materials and other important details. Description continued on attached sheets: \Box Accepted Recommended Medical Treatment: ☐ Yes ☐ No ☐ N/A Employee Signature/Date:_



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Area:



| Step 3: Why did the incident happen? | | |
|--|---|--|
| Unsafe workplace conditions: (Check all that apply) ☐ Inadequate guard ☐ Unguarded hazard ☐ Safety device is defective ☐ Tool or equipment defective ☐ Workstation layout is hazardous ☐ Unsafe lighting ☐ Unsafe ventilation ☐ Lack of needed personal protective equipment ☐ Lack of appropriate equipment / tools ☐ Unsafe clothing ☐ No training or insufficient training ☐ Other: ☐ Why did the unsafe conditions exist? | Unsafe acts by people: (Check all that apply) Operating without permission Operating at unsafe speed Servicing equipment that has power to it Making a safety device inoperative Using defective equipment Using equipment in an unapproved way Unsafe lifting Taking an unsafe position or posture Distraction, teasing, horseplay Failure to wear personal protective equipment Failure to use the available equipment / tools Other: Why did the unsafe acts occur? | |
| Is there a reward such as "the job can be done more quickly "o | r "the product is less likely to be damaged"? Yes No | |
| May have this encouraged the unsafe condition or act? | ☐ Yes ☐ No | |
| Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No | | |
| Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No | | |
| Other Comments: | | |



Name: _____

PREMIER MAGNESIA - GILES CHEMICAL COMPANY PROCEDURE / FORM

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Date :_____

| | ou suggest to prevent this | s incident/near miss from | n happening again? |
|--------------------------|-----------------------------|--------------------------------|---------------------------|
| ☐ Stop this activity | ☐ Guard the hazard | ☐ Train the employee(s) | ☐ Train the supervisor(s) |
| ☐ Redesign task steps | ☐ Redesign work station | ☐ Write a new policy/rule | ☐ Enforce existing policy |
| ☐ Routinely inspect for | r the hazard Personal P | rotective Equipment 🚨 Otho | er: |
| What corrective action | should be (or has been) don | e to carry out the suggestion(| s) checked above? |
| | | | |
| Description continued of | on attached sheets: | | |
| Has corrective action be | een implemented and if so, | date of implementation? | Yes No Date: |
| | | | |
| Step 5: Who comple | eted and reviewed this fo | orm? (Please Print) | |
| Written by: Department: | | Title: Date: | |
| - | on team members (If appl | | |
| 1 turnes of miresonguis | on teams memoria (in app. | | |
| | | | |
| Has Temporary Ager | cy been notified of accide | ent/injury: | Initials/Date: |
| | | | |
| Reviewed by: | | | |
| Name: | Tit | le: | Date: |
| Name: | Ti | tle: | Date : |

Title: _____



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TRAINING DOCUMENTATION

| | EMPLOYEE | TITLE | SIGNATURE | DATE |
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| Revision Number | Revision Date | Revision Author | Revision Description |
|--------------------|------------------|--------------------|---|
| 00 | 06/01/2009 | PT | New Document Replace Reporting Injuries and Serious Incident Procedures (Injury Reporting Procedure-Employees, Injury Reporting Procedure Management) |
| 01 | 09/15/11 | DD/SL | -Revised Procedure – Included Form |
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