INCIDENT

INVESTIGATION

Steingass Mechanical Contracting, Inc.
754 Progress Drive
Medina, Ohio 44256
(330) 725-6090

INCIDENT INVESTIGATION

It shall be Steingass Mechanical Contracting, Inc.'s policy to not only investigate injuries, but to investigate all incidents on the same day of the incident to determine the cause, and implement corrective measures. Results will be used to pinpoint causes and prevention objectives. Also, incident causes and injuries will be monitored so as to recognize trends and evaluate the effectiveness of the program.

Steingass Mechanical Contracting, Inc.'s jobsite foremen shall have the responsibility for incident investigation. Each foreman shall be trained in their roles and responsibilities for incident reports and investigative techniques. The reports will be prepared and include incident report forms and a detailed narrative statement concerning the events. The format of the narrative report will include an introduction, methodology, summary of the incident, investigative board member names, narrative of the event, findings and recommendations. Photographs, witness statements, drawings, etc. will be included. The results will be forwarded to management.

Steingass Mechanical Contracting, Inc. shall ensure that proper equipment will be available to assist and/or conduct an investigation. Evidence such as people, positions of equipment, parts and papers will be preserved, secured and collected through notes, photographs, witness statements, flagging, and impoundment of documents and equipment.

As stated in our Company Drug and Alcohol Policy, we believe that employees with drug and alcohol abuse problems make up only a small fraction of the nation's work force. However, because of our concern for ***all our employees*** and our commitment to safety and health, any employee involved in a workplace incident, which requires medical attention and or property damage, shall voluntarily submit to a drug and alcohol screening as outlined our Drug and Alcohol Policy.

A. Ensure that the Medical Provider receives the documents at the time of incident.

B. Contact Al Lesure at (330) 725-6090 or to report the incident.

C. The following form titled: <u>Steingass Mechanical Contracting, Inc. Supervisor's Incident Investigation Report</u> shall be completed immediately after an incident even where there is no injury, and should be submitted to the office.

D. The following form titled: <u>Steingass Mechanical Contracting, Inc. Employee Incident Investigation Report</u> shall be completed at the time of an incident and submitted to the office.

E. The following form titled: <u>Steingass Mechanical Contracting, Inc. First Aid Report Form</u> shall be completed at the time First Aid is administered.

F. The following form titled: <u>Steingass Mechanical Contracting, Inc. Witness Statement</u> shall be completed at the time First Aid is administered.

G. Required incidents will be verbally reported to OSHA within 8 hours of discovery. All incidents will be reported to the owner/client in a timely manner (within 24 hours).

H. Written records will be kept and maintained for 5 years of all work related fatalities, injuries and illnesses. The safety director will be responsible for recording "recordable" injury or illness on an OSHA 300 log and 301 incident reports within 7 calendar days of receiving notification of a recordable injury or illness. The annual summary (OSHA 300A) will be certified by our president and posted in a conspicuous place and shall not be altered, defaced or covered by other material. This summary will be posted no later than February 1st of the year following the year covered by these records and will remain in place until April 30th.

MEDICAL PROVIDERS PACKAGE

If there is an injury on the job, provide the following documentation to the Medical Provider at time of injury to ensure payment.

Name: **Location:** **Phone:**	**Name:** **Location:** **Phone:**
Name: **Location:** **Phone:**	**Name:** **Location:** **Phone:**

NOTE:

Don't forget to complete the individual Incident Report Forms located in your Safety and Health Policy Manual.

TO THE MEDICAL PROVIDER

The personal safety and health of each employee of this company is of primary importance. We consider these aspects a very important measure of our success.

When there is an incident on the job that requires medical attention; we would request that you follow our claims protocol which includes **post accident drug testing**.

The documents attached are needed to administer Workers' Compensation effectively. Your cooperation will reduce the hardship for our employee and expedite payment for your services.

If you have any questions, please contact
Al Lesure at (330) 725-6090
IMMEDIATELY!

CONSENT TO PHYSICAL EXAMINATION INCLUDING ALCOHOL AND DRUG TESTING

Consent and Release Form for Employees and Applicants

I, ______________________________, (applicant or employee name), as an employee / applicant of Steingass Mechanical Contracting, Inc. (hereafter, the "Company"), hereby acknowledge that the Company's policy requires me to submit to urine drug testing and/or breath alcohol testing.

I hereby freely and voluntarily consent to this request through urine, blood, breathe, saliva, and/or hair and to the analysis of such samples by such laboratories as selected by the company and I agree to participate in the testing program.

I hereby and herewith release the Company, its employees, agents and contractors from any and all liability whatsoever occurring from my participation in the operation of the program, from this request for testing, from the actual testing procedures, and from decisions made concerning any application for or continuation of employment based on the results of the analysis.

I hereby authorize the release of my drug and/or alcohol test results to the contractor's Medical Review Officer (MRO), and/or to the Company's examining physician, as provided by the Company's policy and that the release of this information does not need my further consent.

I further acknowledge that the Company has provided me with an opportunity to ask questions related to its drug and alcohol testing program and that all my questions have been answered.

I understand that my refusal to undergo alcohol and/or drug testing will result in my application not being considered further or if employed, to be in violation of the company's policy and I will be subject to the disciplinary action outlined within the scope of the policy.

Employee / Applicant Signature:____________________________Date:_______________

Employee / Applicant Printed Name:____

Witness Signature and Printed Name:____

WORKERS' COMPENSATION MCO INFORMATION CARD

FRONT

BACK

Supervisor's Incident Investigation Report Form

Person's Name:____

Employee's Address:____

Employee's Phone Number:____

Sex ____ **Age** ____ **Date of Birth** ________________

Date of Incident:_________________, **20** ____ **Time:**_______________**A.M. or P.M.**

If Fatal, Date of Death:____________,**20** ____**Time:**_______________ **A.M. or P. M.**

Occupation:______________________________**Shift:**__________________________

LOCATION/JOBSITE where incident occurred:____

____

Description of Incident: (BE SPECIFIC: Describe the sequence of events that directly led to the

incident:____

____

____

Part of Body Affected if applicable: (BE SPECIFIC: for example, right elbow, left knee, right index

finger)____

____

Type of injury if applicable: (BE SPECIFIC: for example, bruise, scrape, laceration, pull)

____

____

Was First Aid provided at the scene if applicable? ☐**Yes** ☐**No**

If YES, describe:_________________________

____

Was the person performing regular job at the time of incident? ☐**Yes** ☐**No**

Specify if not:____
____
____

Length of service :____

Time shift started:__________**A.M. P.M.** **Overtime?** ☐**Yes** ☐**No**

Was weather a factor? ☐**Yes** ☐**No**

Environmental condition at the time of incident:____

Was machinery/equipment involved? ☐**Yes** ☐**No**

If yes, describe:____
____
____

Corrective action(s) taken? ☐**Yes** ☐**No**

Describe:____
____
____

Disciplinary action(s) taken? ☐**Yes** ☐**No**

Describe:____
____
____

Employee Incident Report

To be filled out and signed by employee(s)

Name: ____

Home Address: ____

Home Phone: ( ) ____

Birth Date: ______________ **Age:**_________ **Sex:** ☐Male ☐Female

LOCATION/JOBSITE where incident occurred:______________________________

____

Description of incident (Describe the sequence of events that directly caused the incident, disease or fatality):______________________________

____

Part(s) of body affected if applicable: (BE SPECIFIC: for example, right elbow, left knee, right index finger):______________________________

____

Type of injury if applicable: (BE SPECIFIC: for example, bruise, scrape, laceration, pull):

____

____

Did you report this incident to anyone? ☐Yes ☐No **If NO, why?**

____

If YES, to whom?____

Name **Title/Position** **Date**

Did anyone else observe what happened? ☐Yes ☐No

If YES, whom?____

____

Was First Aid provided at the scene? ☐Yes ☐No

When?______________________**Where?**______________________

If treatment was not sought immediately, explain why?______________________

____

I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider that attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Ohio Industrial Commission and my employer listed in this claim.

Signed:______________________________ **Date:** ______________

Title: ______________________________

First - Aid Report Form

Date: _______________________________ **Case No.**____

Name: ____ **Male**☐ **Female**☐

Supervisor: ____

Date of Treatment: ________________________________ **Time:** _______ **A.M./P.M.**

Type of Injury: ____

Nature of Treatment:____

Subsequent Action Taken:

☐**Referred to Physician** ☐**Sent to Hospital** ☐**Sent Home**

☐**Returned to Work** ☐**Declined Treatment**

☐**Other (Explain)**____

____

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Signed:____ **Date:** __________________

Title: ____

WITNESS STATEMENT TO INCIDENT

____

____

____

____

____

____

EMPLOYER'S DETAILED STATEMENT

____

____

____

____

____

____

____

By:________________________________ **Title/Position:**________________________

Address:____

Telephone: (   )__________________ **Date:**___________________________________