

**ADVANCED EXPLORATIONS INC.
ROCHE BAY MAGNETITE PROJECT**



APPENDIX A



ADVANCED EXPLORATIONS INC.
JOB SAFETY ANALYSIS FORM

Title of Job / Operation:

Date:

Page

of

ISA Number:

Person(s) performing Job:

Employee(s) Observed:

Division:

Zone:

Analysis made by:

Supervisor:

Analysis approved by:

Sequence of Basic Job Steps

Potential / Accidents or Hazards of each Step

Recommended Safe Job Procedures at each Step

1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

- 1 Struck By (SB)
- 2 Struck Against (SA)
- 3 Contacted By (CB)
- 4 Contact With (CW)

- 5 Caught On (CO)
- 6 Caught In (CI)
- 7 Caught Between (CBT)
- 8 Fall - Same Level (FS)

- 9 Fall to Below (FB)
- 10 Overexertion (OE)
- 11 Exposure (E)
- 12



Job Safety Analysis Form

Name of Organisation Completing the Work:		Job Name:	
Task:		Job Number:	
Principal Contractor:		Job Location:	
Date the JSA was prepared:		Number of pages in this JSA:	
This JSA has been reviewed by:		This JSA has been discussed with:	
Principal Contractor of Representative (signature):		Employee/subcontractor (signature):	
Position:		Date:	
Item Number	Work Activity (the job down into steps)	Hazard (What could harm someone?)	Risk Control (What can be done to make the job safe?)
			Person Responsible (Who will make sure it Happens)
			Completion (Date and Signoff)

Item Number	Work Activity (Break the job down into steps)	Hazard (What could harm someone?)	Risk Control (What can be done to make the job safe?)	Person Responsible (Who will make sure it happens)	Completion (Date and Signoff)

[illegible]



**ADVANCED EXPLORATIONS INC.
MODIFIED WORK
RECOMMENDATION FROM PHYSICIAN**

Advanced Explorations Inc. has a light duty program to rehabilitate injured employees. Where practicable, the Company endeavors to find a suitable job to accommodate a worker's injury. We therefore ask for your cooperation in completing the following form:

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Employee name: _____

Occupational Injury?

Yes

☐

No

☐

Number of days to recover?

Employee may return to work for Regular duty on:

Employee may return to work for Light duty on:

Light Duty for what length of time:

Work restrictions (if any) and/or comments:

Worker has been referred to:

(Physician's Name)

for additional treatment.

We thank you for treatment of this worker and for your medical assessment of his injuries.

Date

Attending Physician



ADVANCED EXPLORATIONS INC.
BEHAVIOR BASED SAFETY
FIRST REPORT OF EMPLOYEE INJURY

CLAIM NUMBER:			
Name of Injured:		SIN:	
Home Telephone nr:		Job Title:	
Home Address:			
Street		City	Prov/State
Date of Birth:		Married / Single:	Code
yyy mm dd			
Date of Hire:		Rate of Pay:	per
yyy mm dd		\$	hr / day / mo
Date of Injury / Onset of Illness:		Time:	
yyy mm dd		AM/PM	
Curr. shift worked from:		to	Days since last day off:
Location of Accident:		Supervisor:	
Describe Injury (part(s) of body, specify left of right):			
What happened to cause the injury?			
Name(s) and phone # of Witness(es):			
To which medical facility was the injured taken?			
Treating Physician:		Phone nr:	
Address:			
Street		City	Prov/State
Type of treatment:		Code	
Was the treating physician informed that AEI provides temporary light duty?			
When did the employee return to work?		Is it the pre-injury job?	
Describe the equipment / tools that may have been involved (include model #, size & weight) if known:			
What immediate action has been taken or will be taken to prevent this kind of accident in future?			
Details of Office reporting the accident:			
Date:		Supervisor's Signature:	
yyy mm dd			

Worker's Certification: By signing below, I am certifying that the above is true and correct to the best of my knowledge, and that I have provided this information to the Company, in order to file a Workman's Compensation Claim. I am also authorizing any health professional who treats me to provide me, my employer, my employer's insurance company or, if in Canada, the Workplace Safety and Insurance Board (WSIB) or equivalent, with information about my functional abilities or other pertinent medical information as may be permissible by law.

Signature:

Date:

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7		
8		
9		
10		
Review Recent Accidents:		
Suggestions made:		
New Business:		



Tailgate Safety Meeting

(Use to record any impromptu gathering)

Group Name: _____ Camp: _____ Date: _____

Persons in Attendance: _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

General Topics Covered: _____

Group Leader Signature: _____

(Turn in to Site Supervisor)



ADVANCED
EXPLORATIONS
INC.

**ADVANCED EXPLORATIONS INC.
BEHAVIOR BASED SAFETY
ACCIDENT INVESTIGATION REPORT**

Company:

WCB Reference Number:

Type of accident (multiple selections possible):

Injury		<input type="checkbox"/>	Property Damage / Loss to Process		<input type="checkbox"/>	Incident (potential loss)		<input type="checkbox"/>
A	First Aid	<input type="checkbox"/>	1	Equipment / Property Damage	<input type="checkbox"/>	1	Equipment / Property Damage	<input type="checkbox"/>
M	Medical Aid Only	<input type="checkbox"/>	2	Fire	<input type="checkbox"/>	2	Injury	<input type="checkbox"/>
L	Lost Time	<input type="checkbox"/>	3	Loss to Process	<input type="checkbox"/>	3	Loss to Process	<input type="checkbox"/>
F	Fatal	<input type="checkbox"/>	4	Environment	<input type="checkbox"/>	4	Environment	<input type="checkbox"/>

Name of injured:

Describe Loss:

Describe Potential Loss:

Payroll nr:

Describe Injury:

Location of Incident:

Date of Incident:

Date Reported:

Time:

Time:

Describe how the incident occurred; include what the person(s) were doing, trying to do and anything unusual.

Is there a written job procedure for the job performed?

Yes:

No:

N/A:

Identify equipment / materials involved (make and model, size, weight, shape where pertinent):

Witness Name (1)

Witness Name (2)

Witness Name (3)

Number

Number

Number

Loss Potential

Potential Severity

Probability of a Recurrence	Death, permanent total disability or property damage > \$100,000	Lost time injury or property damage between \$10,000 and \$100,000	Medical aid injury only or property damage between \$1,000 and \$10,000	First aid injury only or property damage < \$1,000
Frequent	A <input type="checkbox"/>	D <input type="checkbox"/>	G <input type="checkbox"/>	J <input type="checkbox"/>
Occasional	B <input type="checkbox"/>	E <input type="checkbox"/>	H <input type="checkbox"/>	K <input type="checkbox"/>
Rare	C <input type="checkbox"/>	F <input type="checkbox"/>	I <input type="checkbox"/>	L <input type="checkbox"/>

Supervisor:

Investigator:

Date:

Worker representative:

2nd Line Supervisor:

Dept Head:

Comments:

IMMEDIATE / DIRECT CAUSES

Identify the substandard action(s) and condition(s) that caused or could have caused this accident.

For each item check 'Yes' or 'No'. Explain 'Yes' selections in the space below.

Yes	No	Code	Substandard Actions	Yes	No	Code	Substandard Conditions
<input type="checkbox"/>	<input type="checkbox"/>	01	Operating equipment without authority	<input type="checkbox"/>	<input type="checkbox"/>	21	Inadequate guards or barriers
<input type="checkbox"/>	<input type="checkbox"/>	02	Failure to warn	<input type="checkbox"/>	<input type="checkbox"/>	22	Inadequate ground support
<input type="checkbox"/>	<input type="checkbox"/>	03	Failure to secure / make safe	<input type="checkbox"/>	<input type="checkbox"/>	23	Inadequate / improper protective equipment
<input type="checkbox"/>	<input type="checkbox"/>	04	Operating at improper speed	<input type="checkbox"/>	<input type="checkbox"/>	24	Defective equipment, tools or materials
<input type="checkbox"/>	<input type="checkbox"/>	05	Making safety devices inoperable	<input type="checkbox"/>	<input type="checkbox"/>	25	Congestion or restricted action
<input type="checkbox"/>	<input type="checkbox"/>	06	Removing safety devices	<input type="checkbox"/>	<input type="checkbox"/>	26	Inadequate warning system
<input type="checkbox"/>	<input type="checkbox"/>	07	Using defective equipment	<input type="checkbox"/>	<input type="checkbox"/>	27	Fire and explosion hazards
<input type="checkbox"/>	<input type="checkbox"/>	08	Using equipment improperly	<input type="checkbox"/>	<input type="checkbox"/>	28	Substandard housekeeping
<input type="checkbox"/>	<input type="checkbox"/>	09	Failure to use P.P.E. properly	<input type="checkbox"/>	<input type="checkbox"/>	29	Hazardous environmental conditions: gases, dust, smoke, fumes, vapours
<input type="checkbox"/>	<input type="checkbox"/>	10	Improper loading	<input type="checkbox"/>	<input type="checkbox"/>	30	Noise exposure
<input type="checkbox"/>	<input type="checkbox"/>	11	Improper placement	<input type="checkbox"/>	<input type="checkbox"/>	31	Radiation exposure
<input type="checkbox"/>	<input type="checkbox"/>	12	Improper lifting	<input type="checkbox"/>	<input type="checkbox"/>	32	High or low temperature exposure
<input type="checkbox"/>	<input type="checkbox"/>	13	Improper position for task	<input type="checkbox"/>	<input type="checkbox"/>	33	Inadequate or excessive illumination
<input type="checkbox"/>	<input type="checkbox"/>	14	Horseplay	<input type="checkbox"/>	<input type="checkbox"/>	34	Inadequate ventilation
<input type="checkbox"/>	<input type="checkbox"/>	15	Influence of alcohol or drugs	<input type="checkbox"/>	<input type="checkbox"/>	35	Ground conditions

Code How did the immediate / direct causes contribute to the accident?

BASIC / UNDERLYING CAUSES

Identify the reason for the existence of the substandard actions and conditions selected above by marking each factor 'Yes' or 'No'.

Give the basic / underlying cause for each selected immediate / direct cause and explain in the space below.

Yes	No	Code	Personal Factors	Yes	No	Code	Job Factors
<input type="checkbox"/>	<input type="checkbox"/>	61	Inadequate physical capability	<input type="checkbox"/>	<input type="checkbox"/>	71	Inadequate leadership / supervision
<input type="checkbox"/>	<input type="checkbox"/>	62	Lack of knowledge	<input type="checkbox"/>	<input type="checkbox"/>	72	Inadequate engineering
<input type="checkbox"/>	<input type="checkbox"/>	63	Lack of skill	<input type="checkbox"/>	<input type="checkbox"/>	73	Inadequate purchasing
<input type="checkbox"/>	<input type="checkbox"/>	64	Stress (physical or mental)	<input type="checkbox"/>	<input type="checkbox"/>	74	Inadequate maintenance
<input type="checkbox"/>	<input type="checkbox"/>	65	Improper motivation	<input type="checkbox"/>	<input type="checkbox"/>	75	Inadequate tools / equipment
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	76	Inadequate work standards
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	77	Wear and tear
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	78	Abuse or misuse

Immediate / Direct Code	Basic / Underlying Code	How does the immediate / direct cause stem from the Basic / Underlying cause?

CONTROL

Basic / underlying causes of accidents are the result of a lack of control. Lack of control in this accident was the result of (multiple selections possible):

Inadequate Program	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Inadequate Program Standards	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Inadequate Compliance to Program Standards	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

ACTION TAKEN				
Cause code(s)	What action has already been taken to prevent similar occurrences?	Responsibility		

ACTION TO BE TAKEN				
Cause code(s)	What action is recommended to be taken to prevent and/or control similar occurrences?	Responsibility	Date to be completed	Date completed

SKETCH

INFORMATION
Employee postal address:
Social insurance number:
Date of birth:
Contract start date:
Employment start date:
Office use only:



ADVANCED EXPLORATIONS INC. BEHAVIOR BASED SAFETY ACCIDENT STATISTICS REPORT

Name of Injured:		Payroll nr:		Sex:	Age:	Hire date:	WCB ref nr:
Occupation (at time of injury):						Regular <input type="checkbox"/>	Relief <input type="checkbox"/>
Experience in occupation:		0-6mo <input type="checkbox"/>	7-12mo <input type="checkbox"/>	1-2yr <input type="checkbox"/>	3-5yr <input type="checkbox"/>	6-10yr <input type="checkbox"/>	11-15yr <input type="checkbox"/>
Identify common core program for which injured is accredited:		Mine <input type="checkbox"/>	Mill <input type="checkbox"/>	Diamond drill <input type="checkbox"/>	Supervisor <input type="checkbox"/>		
Identify MHSA Training program for which the injured is accredited:		Surface <input type="checkbox"/>	Underground <input type="checkbox"/>	Coal <input type="checkbox"/>			
What training had been given in the safe performance of the task? (multiple selections possible):							
Apprenticeship <input type="checkbox"/>		Common Core Modules <input type="checkbox"/>	Task Training <input type="checkbox"/>	Specialty Modules <input type="checkbox"/>	Specify		
WHMIS <input type="checkbox"/>		Other <input type="checkbox"/>	Specify	Not Applicable <input type="checkbox"/>	Not Trained <input type="checkbox"/>		
At time of incident, employee was on:		Individual/Small Crew Incentive <input type="checkbox"/>		Company/Department Incentive <input type="checkbox"/>		Not on Incentive <input type="checkbox"/>	
Shift Time		Shift Type		Overtime Shift			
Start		Steady <input type="checkbox"/>		Overtime Hours		<input type="checkbox"/>	
End		Rotating <input type="checkbox"/>		Not Overtime		<input type="checkbox"/>	
How many complete shifts has been worked since the last 24 hour break from work?							
First Aid							
Describe injury (nature and part(s) of body):							
Number of persons requiring outside medical aid due to this incident:							
To your knowledge, has the worker had a previous similar disability?							
Has modified work been assigned?				Describe:			
Was employee sent/taken to doctor?		By whom?		Date:	First Aid Att. Name:		
Doctor							
Name of Doctor:							
Address of Clinic or Hospital:						Phone:	
Team							
Investigation Team Members:						Date of Investigation:	
Review							
Health and Safety Committee Rep (Union Rep):							
Signature:						Date:	
Health and Safety Committee Rep (Company Rep):							
Signature:						Date:	
Department Head:							
Signature:				Title:		Date:	
Manager:							
Signature:				Title:		Date:	
Injured Worker:							
Signature:						Date:	



ADVANCED EXPLORATIONS INC. BEHAVIOR BASED SAFETY RISK RATING MATRIX

Severity of Consequences	Priority Rating
Catastrophic - Death, permanent disability or property damage > \$100,000	A - First
Major - Lost time injury or property damage between \$10,000 and \$100,000	B - Second
Minor - Reportable injury, no lost time or property damage between \$1,000 and \$10,000	C - Third
Negligible - Minor medical treatment or property damage < \$1,000	D - Fourth

Hazard:

Probability of Occurrence	Severity of Consequences			
	Catastrophic	Major	Minor	Negligible
Nearly Certain	A	A	A	C
High Probability	A	A	B	C
Moderate Probability	A	B	B	D
Low Probability	A	B	C	D
Not Probable	B	C	C	D

Hazard:

Probability of Occurrence	Severity of Consequences			
	Catastrophic	Major	Minor	Negligible
Nearly Certain	A	A	A	C
High Probability	A	A	B	C
Moderate Probability	A	B	B	D
Low Probability	A	B	C	D
Not Probable	B	C	C	D

Hazard:

Probability of Occurrence	Severity of Consequences			
	Catastrophic	Major	Minor	Negligible
Nearly Certain	A	A	A	C
High Probability	A	A	B	C
Moderate Probability	A	B	B	D
Low Probability	A	B	C	D
Not Probable	B	C	C	D

Hazard:

Probability of Occurrence	Severity of Consequences			
	Catastrophic	Major	Minor	Negligible
Nearly Certain	A	A	A	C
High Probability	A	A	B	C
Moderate Probability	A	B	B	D
Low Probability	A	B	C	D
Not Probable	B	C	C	D



**ADVANCED EXPLORATIONS INC.
SAFE PRODUCTION
HAZARD REPORT FORM**

Person Reporting the Hazard:

Date: _____

Name: _____

Location: _____

Nature of the Hazard:

Suggestion to correct the hazard / Action(s) taken to correct the hazard:

Signature: _____

Date: _____

This section to be completed by Supervision:

Supervisor's Name: _____

Date: _____

Comments:

If required:

Manager's Name: _____

Date: _____

Comments:

Corrective Action (target dates to be indicated):

To be completed by: _____

Completion Date: _____

Authorization of Corrective Action:

Name: _____

Position: _____

Signature: _____

Date: _____



HAZARD REPORT FORM

Step 1 – To Be Completed by Worker

Date of Report: _____ Camp: _____

Name of Worker: _____

Department: _____

Name of Supervisor Reported To: _____

Description of Hazard: _____

Suggested Corrective action (if any): _____

Step 2 – To Be Completed by Supervisor

Date of Response: _____

Name of Supervisor (if different from above): _____

Supervisor Response: _____



ADVANCED EXPLORATIONS INC. SAFE PRODUCTION 5-POINT SAFETY SYSTEM

Daily Safety Production Report

Date:	Shift:	Day <input type="checkbox"/>	Night <input type="checkbox"/>
Work Area:			
Team member 1:		Team member 2:	
Team member 3:		Supervisor:	
Daily Work Instructions:			

Tools & Material: (Employee to report all lost and material used on current shift)			Lost since start of last shift:		
1)	Available:	Used:	5)	Available:	Used:
2)	Available:	Used:	6)	Available:	Used:
3)	Available:	Used:	7)	Available:	Used:
4)	Available:	Used:	8)	Available:	Used:

5-Point Safety:

- Are the entrances and the travel way to your workplace in good order?
- Is your workplace in good order?
 - Is your equipment in good condition?
- Are you working properly? (proper tools, standard procedures, etc.)
 Yes ☐ No ☐

If "No", explain why

What corrective action was taken or should be taken to rectify the problem?

- Do an act of safety. (Comment and check list below)
- Can you continue to work SAFELY?
 Yes ☐ No ☐
- Do you have the ability, tools and attitude to work safely?
 Yes ☐ No ☐

If "No", then you must correct the situation NOW!

Mark Checklist: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Team member 1	Team member 2	Team member 3	Supervisor
1. I understand today's job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I have and will use my P.P.E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have tagged in and reported to my supervisor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are the entrances and travelways to my worksite in good order?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the workplace and equipment in good order and safe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Can the work be done safely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I will work safely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I shall take care and look out for my fellow workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I will leave my work site clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I will tag out and report to my supervisor at the end of my shift.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signatures:

Team member 1:	Team member 2:	Time Visited:
Team member 3:	Supervisor:	



5 POINT SAFETY SYSTEM CHECKLIST

1. Check entrance and travel way.

Ground conditions? _____

Ground support? _____

Travel way unobstructed? _____

Blasting system shorted? _____

Ventilation system? _____

Guards/Barriers in place? _____

Housekeeping? _____

Open holes? _____

2. Are workplace and equipment in good working order?

Ground conditions? _____

Ground support? _____

Water sprays? _____

P.P.E.? _____

Face prepared? _____

Housekeeping? _____

Ventilation system? _____

Tools & Equipment? _____

Open holes? _____

Guard/barriers? _____

3. Are employees working properly?

Controlled all hazards? _____

Following procedures? _____

Wearing P.P.E.? _____

Working to standards? _____

4. Do an act of safety

5. Can and will employees continue to work properly?

**ADVANCED EXPLORATIONS INC.
ROCHE BAY MAGNETITE PROJECT**

APPENDIX B

What are my incident reporting responsibilities?

The following chart outlines your incident reporting responsibilities:

Incident Type	Workers' Compensation Acts	Safety Act: General Safety Regulations	Mine Health and Safety Act/ Regulations
Death	Within 3 days complete and submit <i>WSCC Claim: Employer's Report of Injury</i> form.	Immediately submit oral report to WSCC Chief Safety Officer. *35(2)	Immediately submit oral report to a WSCC Inspector of Mines. *16.02(1)
Incident Involving Serious Injury or Incident of a Serious Nature	Within 3 days complete and submit <i>WSCC Claim: Employer's Report of Injury</i> form. Worker completes and submits <i>WSCC Claim: Worker's Report of Injury</i> form.	Within 24 hours submit written or oral report to WSCC Chief Safety Officer. *35(3)	Immediately submit oral report to a WSCC Inspector of Mines. *16.02(1) Within 72 hours submit written report to WSCC Chief Inspector of Mines. *16.02(3)
Incident Involving Non-Serious Injury	Within 3 days complete and submit <i>WSCC Claim: Employer's Report of Injury</i> form. Worker completes and submits <i>WSCC Claim: Worker's Report of Injury</i> form.	Within 1 month submit incident report to WSCC Chief Safety Officer. Report must be signed by a First Aid Representative. *65(2)	Monthly submit written reports to WSCC Chief Inspector of Mines. *16.08
Incident with No Injury	No report required	See <i>Incident of a Serious Nature</i> above.	If the incident is deemed a dangerous occurrence: - within 24 hours submit oral report to a WSCC Inspector of Mines; and *16.02(2) - within 72 hours submit a written report to WSCC Chief Inspector of Mines. *16.02(3)

*As per the Regulations

**To report a workplace incident call the
WSCC 24-Hour Incident Reporting Line at 1-800-661-0792.**

WSSCC CLAIM: EMPLOYER'S REPORT OF INJURY

If there is a question that does not apply, please indicate by writing 'N/A'.

A – Employer Information

1. Business Name		2. Supervisor's Name	
3. Address	Community	Postal Code	Preferred Language
4. Telephone (Include Area Code)	Cell	Fax	Email Address

B – Worker Information

5. First Name		Last Name	
6. Mailing Address		Postal Code	
7. Residential Address (if different than above)		8. Date of Birth	9. Male <input type="checkbox"/> Female <input type="checkbox"/>
10. Telephone (Include Area Code)	Cell	Email Address	
11. Social Insurance Number		12. Single <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
13. Number of Dependents	14. Worker's Occupation		15. Is a job description available? Yes <input type="checkbox"/> No <input type="checkbox"/>
16. Does the worker work in more than one Province/Territory for this employer? <input type="checkbox"/> Yes If yes, please list the Provinces/Territories: <input type="checkbox"/> No		17. Is the worker a subcontractor? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		18. Is the worker an owner or operator? Yes <input type="checkbox"/> No <input type="checkbox"/>	

C – Incident Details

19. Place of Incident – Name of City/Town		Province/Territory	
20. Incident Date	Date first reported to Employer	Date first disabled from work	
Time: AM PM	Time: AM PM		
21. Did incident occur on employer's premises? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, where?			
22. Does the worker have a job to return to? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please attach an explanation			
23. Was first aid provided? Yes <input type="checkbox"/> No <input type="checkbox"/> By whom:		24. Was any other treatment sought by worker? Yes <input type="checkbox"/> No <input type="checkbox"/>	
25. If other treatment was sought, please complete the following:			
Name of Health Care facility worker was treated at:		Name of attending Health Care Professional:	

D – Reporting Details / Return to Work (Give full explanations and attach extra sheets if necessary)

26. Were the worker's actions at the time of injury for the purpose of your business? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please attach an explanation	
27. Is the activity part of the worker's regular work? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please attach an explanation	28. Are you satisfied that the incident occurred as reported? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please attach an explanation
29. Please describe the incident in as much detail as possible. Include: where it took place, what the worker was doing; what equipment was being used; and, whether gas, chemicals or extreme temperatures were involved. (Attach sheet if necessary)	
30. What part of the body was injured? (left/right side, hand, eye, back, etc.) What type of injury? (sprain, bruise, fracture etc.)	
31. Was any other person not in your employ, at fault or involved in the incident? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach an explanation	
32. Is light duty available? Yes <input type="checkbox"/> No <input type="checkbox"/> Has light duty been offered to the worker? Yes <input type="checkbox"/> No <input type="checkbox"/> When? Please provide a list of light duties offered	
33. Has worker returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/> When? Worker returned to: Regular duties <input type="checkbox"/> Light duties <input type="checkbox"/>	
34. If worker has lost time from work, please provide the date the worker first lost time.	35. If time was lost, and worker has since returned, please provide the date worker returned to work.

PLEASE PROCEED TO SECTION "E" AND "F" ON THE 2ND PAGE. ➔

Workers' Full Name: _____

E – Employment Category

36. Worker's Type of Employment	
A) Permanent <i>Type of Permanent Employment -</i> <input type="checkbox"/> Term (Over 1 year) <input type="checkbox"/> Full / Part time Permanent <input type="checkbox"/> Apprentice <input type="checkbox"/> Relief <input type="checkbox"/> Other	B) Non - Permanent <i>Type of Non-Permanent Employment -</i> <input type="checkbox"/> Term (Under 1 year) <input type="checkbox"/> Seasonal <input type="checkbox"/> Summer Student <input type="checkbox"/> Casual <input type="checkbox"/> Apprentice
37. Is the job subject to lack of work layoffs? Yes <input type="checkbox"/> No <input type="checkbox"/>	38. Is the job subject to seasonal layoffs? Yes <input type="checkbox"/> No <input type="checkbox"/>
39. Date worker was hired YY MM DD	40. What was the contract / term / season start date? YY MM DD
	41. What is the expected contract / term / season end date? YY MM DD

F – Schedule Information

42. Number of days on _____ Number of days off _____	43. Hours per Shift / Day _____	44. Hours per Rotation _____
Please circle days on for one full rotation: M T W T F S S M T W T F S S M T W T F S S M T W T F S S 45. Date rotation started YY MM DD Date rotation ends YY MM DD		

IF NO WORK WAS MISSED and NO CHANGE to duties or pay, proceed to bottom of page and sign, date, and submit this report.
IF WORK WAS MISSED or if duties or pay have been MODIFIED, please answer ALL questions on this form.

G – Wage Information (Please complete all questions)

46. What is the hourly rate of pay? _____ / hr What is the worker's annual gross earnings? _____ <i>If the worker is paid other than hourly or on salary, please attach an explanation.</i>	
47. Does the worker receive any other benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain in detail with amounts or averages: (eg: Vacation pay, Northern Allowance, Bonus)	
48. Does the worker regularly work or get paid for overtime? Yes <input type="checkbox"/> No <input type="checkbox"/>	
49. Provide an estimate of regular overtime hours _____ / day week month <i>Please circle one</i>	50. What is the overtime rate? _____ / hr
51. Are you paying the worker for lost time? Yes <input type="checkbox"/> No <input type="checkbox"/>	52. Will you continue to pay benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> (eg: Northern Allowance)

IMPORTANT:

NOTIFICATION OF AN INCIDENT MUST REACH THE WORKERS' SAFETY AND COMPENSATION COMMISSION OFFICE
WITHIN THREE WORKING DAYS OF THE INCIDENT. IF THE INCIDENT OCCURRED IN THE
NORTHWEST TERRITORIES, PLEASE FAX TO 1-866-277-3677.
IF THE INCIDENT OCCURRED IN NUNAVUT, PLEASE FAX TO 1-867-979-8501.

Any information received as a result of the claims process must be treated as confidential and any further use or disclosure of the information could result in a fine pursuant to the Workers' Compensation Acts.

Completed by (please print)		Signed at (city, town, village)	
Authorized Signature	Phone Number	Date	

ATTENTION:

By law an employer who does not submit a fully completed incident report within 3 business days faces the following penalties:

- \$250 for each occurrence for the first 2 occurrences.
- \$500 for the next 2 occurrences
- \$1,000 for each additional occurrence.

For more information on our Legislation and Policies, please visit our Website
www.wcb.nt.ca • www.wcbnunavut.ca

If you would like assistance filling in this form, or more information, please contact one of our offices listed below

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677

or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501

Webpage • www.wcb.nt.ca or www.wcbnunavut.ca

WSCC CLAIM: WORKER'S REPORT OF INJURY

If there is a question that does not apply, please indicate by writing 'N/A'.

A - Worker Information

1. First Name		2. Last Name	
3. Mailing Address		4. Community	5. Postal Code
6. Residential Address (if different than above)		7. Date of Birth	8. Male <input type="checkbox"/> Female <input type="checkbox"/>
9. Telephone (Include Area Code)	Cell	Fax	Email Address
10. Social Insurance Number		11. Single <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
12. Number of Dependents	13. Job Title	14. Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Inuktitut <input type="checkbox"/> Other	

B - Employer Information

15. Employer Name	16. Address
17. Supervisor's Name	18. Telephone ()

C - Incident Details

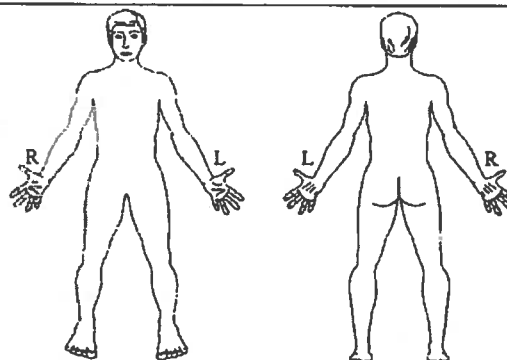
19. Date of Incident	20. Place of Incident - Name of City/Town
Time: AM / PM	
21. Did incident occur on employer's premises? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, where?	
22. Date reported to employer	23. Name and position of person you reported incident to:
Time: AM / PM	
24. Date first disabled from work	
Time: AM / PM	

IMPORTANT

25. Please describe the incident in as much detail as possible. Include: where it took place; what you were doing; what equipment you were using; and, whether gas, chemicals, or extreme temperatures were involved. (Attach sheet if necessary)

What part of the body was injured? (left/right side, hand, eye, back, etc.)

What type of injury? (sprain, bruise, fracture etc.)



26. IMPORTANT - Please list any witnesses Name and Address - include a contact number	Name and Address - include a contact number
--	---

27. Have you been offered light duties? Yes <input type="checkbox"/> No <input type="checkbox"/>	When?
28. Have you returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, <input type="checkbox"/> Light Duties <input type="checkbox"/> Regular Duties	When?
29. Name of Attendant if first aid was provided? Where?	When?
30. What Hospital / Health Care Centre did you go to?	When?
31. Name of attending Health Care Professional	

D. Past Injuries

32. Have you ever had an injury or disability to the same body part? (i.e. left foot, right hand)? Yes <input type="checkbox"/> No <input type="checkbox"/>	When?
33. Have you had previous claims with this Commission, or any other Workers' Compensation Board? If yes, provide dates and nature of injury.	

PLEASE PROCEED TO SECTION "E" AND "F" ON THE 2ND PAGE. →

WORKER'S FULL NAME:

E - Employment Category

34. Worker's Type of Employment A) Permanent <i>Type of Permanent Employment -</i> <input type="checkbox"/> Term (Over 1 year) <input type="checkbox"/> Full / Part time Permanent <input type="checkbox"/> Apprentice <input type="checkbox"/> Relief <input type="checkbox"/> Other		B) Non - Permanent <i>Type of Non-Permanent Employment -</i> <input type="checkbox"/> Term (Under 1 year) <input type="checkbox"/> Seasonal <input type="checkbox"/> Summer Student <input type="checkbox"/> Casual <input type="checkbox"/> Apprentice	
35. Is the job subject to seasonal layoffs? Yes <input type="checkbox"/> No <input type="checkbox"/>		36. Is the job subject to lack of work layoffs? Yes <input type="checkbox"/> No <input type="checkbox"/>	
37. First day of hire YY MM DD			

F - Schedule Information (Please complete all questions that apply)

38. Number of days on _____ Number of days off _____	39. Hours per Shift / Day _____	40. Hours per Rotation _____
41. Please circle days on for one full rotation: M T W T F S S M T W T F S S M T W T F S S M T W T F S S		
42. Date rotation started YY MM DD Date rotation ends YY MM DD		

IF NO WORK WAS MISSED and NO CHANGE to duties or pay, proceed to bottom of page and sign, date, and submit this report.
 IF WORK WAS MISSED or if duties or pay have been MODIFIED, please answer ALL questions on this form.

G - Wage Information (Please complete all questions)

43. What is your hourly rate of pay? _____ / hr <i>If you are paid other than hourly or on salary, please attach an explanation</i>		What is your annual gross earnings? _____	
44. Do you receive any other benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> (eg: Vacation pay, Northern Allowance, Bonus)		If yes, explain in detail with amounts or averages:	
45. Do you regularly work or get paid for overtime? Yes <input type="checkbox"/> No <input type="checkbox"/>			
46. Provide an estimate of regular overtime hours _____ / day week month <i>Please circle</i>		47. What is your overtime rate? _____ / hr	
48. Are you being paid for lost time? Yes <input type="checkbox"/> No <input type="checkbox"/>			
49. Do you have a second job? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you have more than one other employer please list all employers and their contact information)			
Name of second employer: _____		Contact name and phone: _____	

WORKER'S CONSENT

I hereby claim compensation for work-related injuries or disease.

Information Sharing- I understand that the above information about me will be used by the WSCC for the sole purpose of conducting an investigation into this claim. I also understand that the WSCC will need to gather more information about my work incident and medical and work history to administer my claim. For that specific purpose only, some personal information may have to be disclosed to employers, medical personnel and other relevant third parties.

I authorize the WSCC to provide and gather such information from all necessary sources, including hospital and doctors' records, and employer records.

Information Accuracy- I understand that incomplete information from me may delay my claim, and that untrue information from me is unlawful.

I declare the information above is true and accurate. I understand it may be a criminal offence to make a false claim, or to work and earn income while receiving workers' compensation without telling the WSCC.

Signature: _____

Date: _____

Witness: _____

Date: _____

For more information on our Legislation and Policies, please visit our Website
www.wsccl.nt.ca • www.wsccl.nu.ca

If you would like assistance filling in this form, or more information, please contact one of our offices listed below

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 020 3888 • Toll Free: 1-800-661-0782 • Fax: (867) 873-4598 • Toll Free Fax: 1-866-277-3677

Box 659 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501

www.wsccl.nt.ca or www.wsccl.nu.ca

**ADVANCED EXPLORATIONS INC.
ROCHE BAY MAGNETITE PROJECT**



APPENDIX C

Roche Bay “Medical” Emergency Procedures

Helicopter Evacuation:

1. Persons at the scene call for “HELP” via any means available.
2. Medic & a will be dispatched via quickest method available.
 - a. Helicopter if some distance to emergency site.
 - b. Snow machine; QUAD or 6 wheel ranger; if within reasonable distance and quicker reaction time to emergency site.
3. Communicate to all work sites to “STOP WORK” and listen out for further instructions or request for assistance.
4. Drill Foreman & First Aider will be dispatched with track vehicle; equipped with stretcher & backboard; to emergency site.
5. If helicopter not already on scene; will be dispatched to a safe landing site near the emergency scene.
6. AEI Supervisor to maintain communications with emergence site; helicopter & work sites.
7. AEI Supervisor to contact Project Manager in Hall Beach so he can arrange necessary transportation for the injured person to:
 - a. Nursing Station in Hall Beach
 - b. Hospital via Medical Evacuation to Iqaluit medical facility.
8. Helicopter & Medic to return to Roche Bay Camp ASAP so work can resume.

All involved personnel to meet with AEI Supervisor “as soon as practical” to complete a report of the incident.

AEI Project Manager to maintain contact with the person and his family to insure accurate information is being passed on.

In the event that the Helicopter “CAN NOT” fly

1. Persons at the scene call for “HELP” via any means available.
2. Medic & a First Aider to be dispatched to the scene using most expedient means available. Snow machine; QUAD; 6X6 Ranger
3. Drilling Foreman & 2nd First Aider to be dispatched via tracked vehicle equipped with stretcher and backboard.
4. Communicate to all work sites to “STOP WORK” and listen out for further instructions or requests for assistance.
5. Medic to move injured man as practical within the conditions and limitations of the situation.
6. AEI Supervisor to maintain communications with the emergency site and other work sites.
7. AEI Supervisor to contact Project Manager in Hall Beach and inform him of the situation.
8. Medic to be assisted in gaining communication with a medical facility and gain the assistance of a doctor.
9. When able; take the injured man to the nearest medical facility.

Project Manager to facilitate the injured persons movement to medical aid; as soon as possible; with whatever means available.

All involved personnel to meet with AEI Supervisor “as soon as practical” to complete a report of the incident.

Évacuation par hélicoptère

1. Les personnes sur la scène devront appeler pour l'aide selon n'importe quel moyen disponible (radio, « sat phone », etc.). « Help, help, help, emergency, emergency, emergency. » (À ce moment, toute communication par radio est réservée pour le médecin, le foreman, et le superviseur de site).
2. Le médecin sera envoyé selon la méthode la plus efficace, soit :
 - a. Hélicoptère si le site est à une distance; ou
 - b. Quad ou Ranger si cela serait plus vite.
3. Au besoin, le foreman fera une annonce de « Stop Work », vous devriez être à l'écoute pour plus d'informations ou demande d'assistance.
4. Le foreman et un secouriste seront envoyés à la scène avec d'autres équipements selon les besoins du médecin.
5. Si l'hélicoptère n'est pas déjà sur scène, il sera envoyé à un endroit sécuritaire proche de la scène.
6. Le superviseur de site sera le lien de contact entre la scène d'urgence, l'hélicoptère et les aires de travail.
7. Le superviseur de site sera en communication avec Hall Beach pour arranger le transport soit au Hall Beach Nursing Station, ou à l'hôpital à Iqaluit, selon les besoins du blessé.

Toutes les personnes impliquées devront rencontrer le superviseur de site aussitôt que pratique pour compléter un rapport de l'incident.

Évacuation au cas où l'hélicoptère ne peut pas voler

1. Les personnes sur la scène devront appeler pour l'aide selon n'importe quel moyen disponible.
 2. Le paramédical et un secouriste seront envoyés sur scène selon la méthode la plus efficace, soit le « Quad », « Ranger », « Snowmobile », etc.
 3. Le foreman et un autre secouriste seront envoyés avec une machine de neige équipée d'un « stretcher » et « backboard ».
 4. Tous les sites devraient être à l'écoute pour une instruction d'arrêt de travail, de plus amples informations ou de demandes d'aide.
 5. Le paramédical déplacera le blessé autant que pratique selon la situation et les conditions.
 6. Le superviseur de site sera le lien de contact entre la scène d'urgence, l'hélicoptère et les aires de travail.
 7. Le superviseur de site sera en communication avec Hall Beach pour arranger le transport soit au Hall Beach Nursing Station, ou à l'hôpital à Iqaluit, selon les besoins du blessé.
 8. Le paramédical sera assisté à établir la communication avec une facilité médicale pour avoir l'assistance d'un médecin.
 9. Le blessé sera évacué aussitôt que les conditions le permettent.
- Veuillez noter que selon les règlements, il est obligatoire d'avoir un secouriste de niveau 3 sur scène en tout temps (normalement, ceci serait un des cooks). Pourtant, nous avons engagé un paramédical en vue de notre location particulière. Au cas que le paramédical devrait accompagner le blessé à Hall Beach, le travail continuera aux sites non impliqués en autant qu'il y a toujours un secouriste de niveau 3 et un hélicoptère au camp, et que le travail est sécuritaire.

Si vous avez des questions ou commentaires au niveau de la procédure, ou par rapport à d'autres mesures de sécurité, n'hésitez pas à en discuter avec le paramédical, le foreman, ou le superviseur de site.

**ADVANCED EXPLORATIONS INC.
ROCHE BAY MAGNETITE PROJECT**

APPENDIX D



Advanced Explorations Inc.
Emergency Contact Numbers

Contact	Phone Number
Camp Satellite Phone	
Local RCMP	
Project Supervisor	
Local Nursing Station	
Local 24/7 Nurse	
Local Airport	1-800-661-0792
WSCC	
Local Hospital	
AEI Head Office	416-203-0057
NT-NU 24/7 Spill Report Line	1-867-920-8130

**ADVANCED EXPLORATIONS INC.
ROCHE BAY MAGNETITE PROJECT**



APPENDIX E



Advanced Explorations Inc. Camp Orientation Checklist

To be carried out by an on site supervisor.

Name of supervisor: _____

Date: _____

Camp: _____

Check	Item	Points of Interest	Location (ex: Tent #)	Comments
Important Locations				
1	First Aid Tent			Paramedic on site, make sure you are aware of location. Emergency Information to be completed by all!
2	Muster Points			Make sure you are aware of locations.
3	Site Supervisor Office			Make sure you are aware of location.
4	Drill Foreman Office			Make sure you are aware of location.
5	General Office			General use phone and computer, keep it brief.
6	Washrooms			Make sure you are aware of location.
7	Showers			Make sure you are aware of location.
8	Laundry			Make sure you are aware of location.
9	Kitchen & Dinning facilities			Be aware of Breakfast, Lunch and Dinner times.
10	Camp Power Station & Work Shop Storage			Stay out unless authorized.
11	Camp Incinerator & Garbage processing area			Stay out unless authorized.
Equipment				

12	Vehicles		For working on the job, not toys. Beware of patchy terrain. Helmets are mandatory. Vehicle operation training mandatory.
13	Fire Extinguishers		Make sure you are aware of locations.
14	Personal Protective Equipment		If you are missing something, see Site Supervisor.
Rules & Responsibilities			
15	Safety Meetings		Be aware of weekly time and location of meetings.
16	Camp Housing Rules		No smoking in the tents, any problems see camp manager.
17	Zero Tolerance for Drug or Alcohol Consumption or Possession		No drugs or alcohol on site.
18	Leaving Camp		Make sure you have communication with you and know how to use it. Advise Site Supervisor.
19	Job Safety Plan		Become familiar with the plan and forms
20	Emergency Plan and Contacts		Make sure you are familiar with the emergency plan and emergency contacts, including where to locate them in the event of an emergency.
Environmental Awareness			
21	Environmental Footprint		Keep it small. Pick up garbage and put cigarette butts in ashtrays.
22	Archaeological Sites		Be aware and report to Site Supervisor.
23	Wildlife Encounters		Be aware and report all wildlife sightings to the Wildlife Monitor and Site Supervisor.
Spills			
24	Oil and Hazardous Material Spill Contingency Plan		Become familiar with the plan.
25	Spill Incident Responsibilities		Notify Site Supervisor immediately. Refer to Oil and Hazardous Material Spill Contingency Plan in the office.
26	Spill Response Materials		Make sure you are aware of where all of the spill response materials are located.
27	Spill Response Training		Ensure all employees are adequately trained in the use of spill response materials in the event of an incident.
Orientation Forms			
28	Orientation Sign-Off Sheet		To be signed by all employees after orientation meeting

29	Emergency Notification Form		To be filled out by all employees
30	Camp Personnel Location Board		List all tent and bed locations for all employees
31	Hep B & C Shot letters		As required
Additional Points of Interest (list):			
Signature:		Date:	



**Advanced Explorations Inc.
Camp Personnel Location Board**

Tent #	Bed "A"	Bed "B"	Bed "C"	Bed "D"	Notes
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					



CONFIDENTIAL

(Site Supervisor & Medic ONLY)

Emergency Notification Form

Name: _____ Date: _____

Next of kin: _____ Relationship: _____

Address: _____ Phone No. _____

Medications being taken now: _____

Allergies: _____

Recommended treatment if self medicated: _____

Brief family history: (voluntary) _____

Signature: _____ Witness (if required) _____

Confidential

(when completed)

ADVANCED
EXPLORATIONS
INC.



Date: _____

To Whom It May Concern:

_____ is an employee at the _____ Camp operated by Advanced-Exploration Inc. This person handles hazardous waste as part of their daily job. Would you please administer this individual the Hep A & Hep B series of vaccinations, and provide a proof of vaccination record. If you have any questions on the kind of exposure please call 604-759-3432 and ask to speak to the camp Medic. If there is any cost for this service please contact 867-928-8030.

Thank you very kindly,

Project Manager:

Phone:

Email:



Orientation Sign-Off Sheet

Camp:

Date:

Names (Signature):