Appendix A

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 or Representative (signature)			Employee/subcontractor (signature)		
Position		Date	Position	Date	
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?	**Persons responsible** Who will make sure it happens?	**Completion** Date and signoff

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Boart Longyear 's "Job Safety Analysis"

Title of Job/Operation: Date Page of JSA No.

Person(s) performing Job: Employee(s) Observed:

Division: Zone: Analysis Made By:

Supervisor: Rig(s) 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.		

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)

IMMEDIATE / DIRECT CAUSES

Identify the substandard action (2) and condition(s) that caused or could have caused this mishap. For each item check Yes or No. Explain Yes selections in the space below.

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

Code	How did the immediate/direct cause(s) contribute to the mishap?

BASIC / UNDERLYING CAUSES

Identify the reasons 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
☐	☐	61	Inadequate physical capability.	☐	☐	71	Inadequate leadership / supervision.
☐	☐	62	Lack of knowledge.	☐	☐	72	Inadequate engineering.
☐	☐	63	Lack of skill.	☐	☐	73	Inadequate purchasing.
☐	☐	64	Stress (physical or mental).	☐	☐	74	Inadequate maintenance.
☐	☐	65	Improper motivation.	☐	☐	75	Inadequate tools / equipment.
☐	☐			☐	☐	76	Inadequate work standards.
☐	☐			☐	☐	77	Wear and tear.
☐	☐			☐	☐	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 mishaps are the result of Lack of control. Lack of control in this mishap was the result of (multiple selections possible):

Inadequate program	Yes	☐	No	☐
Inadequate program standards	Yes	☐	No	☐
Inadequate compliance to program standards	Yes	☐	No	☐

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

SKETCH

INFORMATION

Employee postal address:

Social insurance number:

Date of birth:

Contract start date:

Employment start date:

Office use only:

BOART LONGYEAR OBSERVATION SHEET

Date: _____ Observer: _____ Contract: _____

Duration: _____ Name of Employee(s): _____

Total Safe Behaviors: _____ X 100 = _____ divided by Total Observations: _____ = % Safe: _____

Use a ✓ mark to indicate each safe behavior, and an X mark to record each at-risk behavior in the space provided. Briefly describe the At-Risk Behaviors observed and Safe Behaviors of note on the comments page.

COMMUNICATION		**WORK HABITS/BODY ACTIONS**	
Assisting/Advising Others		Line of Fire/Body Placement	
Skills/Ability		Line of Fire/Hand Placement	
EQUIPMENT/TOOLS		Eyes on Task	
Safe & Proper Use		Lifting	
WORK SITE/AREA		Bending	
Housekeeping		Twisting	
Trip/Slip Hazard		Climbing	
SUPPORT EQUIPMENT		Jumping	
Operation/Application		Rushing	
Load Condition/Secure		Balance/Traction	
SEGMENT SPECIFIC (Specify)		Overexertion	

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MODIFIED WORK OFFER

Attention: (WCB Adjudicator/Case Manager or Disability Insurer)

Date: _____ RE: Name: _____

Project: _____ Date o Injury/Illness: _____

Contact Phone: _____ Claim #: _____

Contact Fax: _____ Employee #: _____

Please be advised that the above worker who sustained a _____,
(injury/illness)

has been placed on **Modified Work** as of ___(date)___.

In keeping with our policy to consider suitable employment for employees unable to perform their regular duties, we are offering the following **Modified Work Duties.**

_____

_____

_____

_____

_____

_____

We will continually review your progress and adjust the length of this placement as required, based on relevant medical information. Your rate of pay will/will not (circle one) remain at its pre-accident rate.

During this modified work placement, you will be supervised by

_____ .

If you have any concerns or difficulties, please notify the supervisor or project medical personnel immediately. We also request that you meet with _____,
(name) (position)
on a regular basis, at least weekly, to review your progress.

ρ Offer Accepted ρ Offer Declined*

*Refusal could affect your rights to collect benefits

Employee _____
(print) (signature)

Supervisor _____
(print) (signature)

(Your name & title)_____
(print) (signature)

Modified work is available/
Du travail modifié est disponible

BOART LONGYEAR
Boart Longyear Inc.

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

Boart Longyear Inc., a un programme de réhabilitation offrant du travail modifié à ses employés blessés. Lorsque pratique, la compagnie essaie de trouver du travail convenable pour accommoder les blessures de l'employé. Donc, nous vous demandons votre coopération et de remplir ce formulaire.

TO BE COMPLETED BY ATTENDING PHYSICIAN / À REMPLIR PAR LE PRATICIEN TRAITANT

Employee Name / Nom de l'employé:	
Occupational Injury / Blessure au travail? Yes/Oui No/Non	
Number of days to recover / Nombre de jours pour récupérer:	
Employee may return to work on / L'employé pourra retourné au travail le:	Regular Duty / Travail régulier
Employee may return to work on / L'employé pourra retourné au travail le:	Light Duty / Travail léger
Light Duty for what lenght of time / Travail léger pour une durée de:	

Work restrictions (if any) and/or comments / Restriction de travail s'il y a lieu et/ou vos commentaires:

_____

_____

_____

_____

_____

_____

_____

Worker has been referred to / le travailleur a été référé à _____
(physician's name / nom du praticien)
for additional treatment / pour traitements supplémentaires.

We thank you for treatment of this worker and for your medical assesment of his injury / Merci des traitements que vous avez effectué pour notre employé et pour votre évaluation de cette blessure.

_____ _____
Date Attending physician / Praticien traitant

To employee / à l'employé:
Return this form to the Safety Department or to your foreman when you return from treatment.
Veuillez retourner ce formulaire au Service de la sécurité ou à votre contremaître lorsque vous revenez de votre

BOART LONGYEAR

FIRST REPORT OF EMPLOYEE INJURY

Claim # _____

NAME OF INJURED _____ SOCIAL _____ HOME PHONE # _____

HOME ADDRESS _____ DATE OF BIRTH _____
STREET CITY PROV/STATE POSTAL CODE

MARRIED ___ SINGLE ___ RATE OF PAY _____ JOB TITLE _____ DATE OF HIRE _____
(OFFICE USE ONLY)

DATE OF INJURY OR ONSET OF ILLNESS _____ TIME OF INJURY _____ AM / PM

CURRENT SHIFT WORKED FROM _____ TO _____ NUMBER DAYS WORKED SINCE LAST DAY OFF _____

LOCATION (City, Prov. Or State & Country) OF ACCIDENT _____

SUPERVISOR _____ CLIENT _____ MINE NAME & MSHA # _____

DESCRIBE INJURY (part of body involved & specify left or right side) _____

_____

WHAT HAPPENED TO CAUSE THE INJURY? _____

_____

DID ANYONE WITNESS THIS ACCIDENT? _____ IF SO, GIVE NAME & PHONE # _____

WAS THE INJURED TAKEN TO A MEDICAL FACILITY? _____ IF SO, WHERE? _____

TREATING PHYSICIAN _____ PHONE # _____ ADDRESS _____

TYPE OF TREATMENT ADMINISTERED _____

WAS THE TREATING PHYSICIAN MADE AWARE THAT BOART LONGYEAR PROVIDES TEMPORARY LIGHT DUTY? _____

HAS THE EMPLOYEE RETURNED TO WORK? _____ DATE ? _____ DID EMPLOYEE RETURN TO HIS/HER PRE-INJURY JOB? _____

DESCRIBE EQUIPMENT AND/OR 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 INJURY IN THE FUTURE?

_____

_____

_____

BRANCH, ZONE OF OFFICE REPORTING ACCIDENT _____ DATE _____

SUPERVISOR'S SIGNATURE _____

WORKERS 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 Worker 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 _____

Exploration Medical Services

First Aid Record

Date of Illness or Injury: _____ Time: _____

Date of Illness or Injury REPORTED: _____ Time: _____

Full name of injured or ill worker: _____ _____

Description of injury or illness: _____

Description of where the injury or illness began/occurred:

Cause of injury or illness:

First Aid Provided? Yes ☐ (if yes, complete rest of page)

Name of First Aider: _____

First Aider Qualifications:

Emergency First Aid	☐	Emergency Medical Technologist Paramedic	☐
Standard First Aid	☐	Emergency Medical Technician	☐
Advanced First Aid	☐	Emergency Medical Responder	☐
		Nurse	☐

Description of First Aid provided:

WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

EMPLOYER'S REPORT OF ACCIDENT

If a worker is injured at work, you need to complete this form so that the claim can proceed.

Employer Information

Business Name	Contact Person	Email Address
Mailing Address	Community	Postal Code
Telephone (include area code) / Fax (include area code)	Worker's Supervisor Name	

Worker Information

Last Name	First Name	
Street Address		
Mailing Address	Community	Postal Code
Date of Birth (YY | MM | DD)	❑ Male ❑ Female	
Telephone (include area code)	Social Insurance Number	
Worker's Occupation	Is a job description available? ❑ Yes ❑ No If yes, please attach	
What province or territory was the worker hired in?		
Is the worker a subcontractor? ❑ Yes ❑ No	Is the worker an owner or operator? ❑ Yes ❑ No	

Accident Details

1. Place of Accident – Name of City/Town, Province/Territory

2. Was the worker on the employer's premises when the accident occurred? ❑ Yes ❑ No

3. Accident Date (YY | MM | DD)	Time AM / PM	4. Date first reported to employer (YY | MM | DD)	Time AM / PM
5. Date first disabled from work? (YY | MM | DD)	Time AM / PM	6. Time worker commenced work on the day of the accident?	Time AM / PM

7. Does the worker have a job to return to? If no, explain. ❑ Yes ❑ No

8. Was first aid rendered? ❑ Yes ❑ No If yes, when?
By whom?

9. Name and address of attending health care professional

Complete All Questions Below – (Give full explanation – attach extra sheets if necessary)

10. Were the worker's actions at the time of injury for the purpose of your business? ❑ Yes ❑ No

11. Is the activity part of the worker's regular work? ❑ Yes ❑ No If no, explain	12. Are you satisfied the incident occurred as reported? ❑ Yes ❑ No If no, explain

13. Please describe the accident in as much detail as possible. Include where it took place, what the worker was doing at the time of injury, what equipment was being used, and whether gas, chemicals, or extreme temperatures were involved. Was language a contributing factor? (attach sheet if necessary).

14. What part of the worker's body was injured? (left/right side, hand, eye, back, etc.)
What type of injury did they experience? (sprain, bruise, etc.)

15. Was anyone not employed by you involved in the accident? ❑ Yes ❑ No If yes, explain.

16. Was the worker disabled longer than the date of the accident? ❑ Yes ❑ No

17. If no time loss, is the worker performing modified duties? If yes, provide list of duties.

18. Is light duty available? ❑ Yes ❑ No If yes, when? (YY \| MM \| DD)

19. Has the worker been advised of light duties? ❑ Yes ❑ No If yes, when? (YY \| MM \| DD)

20. Please supply a list of duties available. (attach sheet if necessary)

IF THE WORKER WAS DISABLED LONGER THAN THE DATE OF THE ACCIDENT, PLEASE CONTINUE. IF NOT, PLEASE SIGN AT THE BOTTOM OF THE NEXT PAGE.

Worker's Full Name:	WCB Claim Number:

Complete All Questions Below –
Give Full Explanation – attach extra sheets if necessary

21. Has the worker returned to work? ❑ Yes ❑ No If yes, when? | YY | MM | DD |

22. Will you pay the worker for the period of disability? ❑ Yes ❑ No
If yes, for how long? (e.g. 1 month, 6 months, etc.)
Will you continue to pay the employee benefits while the worker is receiving compensation payments? (e.g. travel, Northern living allowance) ❑ Yes ❑ No If yes, please explain

23. Worker's type of employment ❑ permanent ❑ seasonal ❑ casual ❑ summer student ❑ apprentice ❑ part-time

24. Is the job subject to seasonal layoffs ❑ Yes ❑ No
or lack of work layoffs ❑ Yes ❑ No

Wage Information – please complete

25. Date of hire | YY | MM | DD | 26. If non-permanent, what is the expected end date of employment? | YY | MM | DD |

27. Usual hours and days in work week Days off ____________
______ hours ______ days from ______ AM / PM to ______ AM / PM
e.g. 40 hrs/week hours 5 days from 8 (AM) / PM to 5 AM / (PM)

28. If worker works an irregular work week (shifts, turnarounds, etc.), please supply one complete shift cycle
Date shift cycle started ____________ Number of days on ____________ Number of days off ____________

Circle days on:

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 M T W T F S S M T W T F S S

29. What is the hourly rate of pay? ________ /hr
How often is the worker paid? ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Other – please explain

30. Specify amount of time off for lunch Is worker paid for the time? ❑ Yes ❑ No

31. Does the worker receive any other benefits? ❑ Yes If yes, explain and give amounts.
i.e. (vacation pay, settlement allowance, etc.) ❑ No

32. Does the worker regularly work overtime ❑ Yes ❑ No?

33. Provide an estimate of regular overtime hours (weekly / monthly / yearly) ____________
At what rate? ❑ Double-time ❑ Time and a half ❑ Other ____________

34. Give worker's exact gross earnings for the 12 months prior to accident date

IMPORTANT:

NOTIFICATION OF ACCIDENT MUST REACH THE WORKERS' COMPENSATION BOARD OFFICE WITHIN THREE WORKING DAYS OF ACCIDENT. IT IS RECOMMENDED THAT THIS FORM BE FAXED IN THE NORTHWEST TERRITORIES TO 1-866-277-3677 OR IN NUNAVUT AT 1-867-979-8501.

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

If you would like assistance filling in this form, or more information, please contact one of our offices listed below, or go to our website: www.wcb.nt.ca or www.wcbnunavut.ca.

"... An employer who fails to submit completed accident reports on a timely basis is liable to penalties as follow:

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

Decisions not to apply the late reporting penalty must be approved by the NWT or Nunavut manager of Claimant Services.

Where the employer fails to submit accident reports as required or requested by the board, the board may make a special investigation of the facts and circumstances surrounding an injury and charge the cost of the investigation to the employer (per Policy 11.02 '*Reporting an Accident*', WCB of the Northwest Territories and Nunavut Policy Manual)."

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) 979-8501

Ce formulaire est disponible en français.
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Taanna tatatiriaik atuinnaunnouvuq Inuktitut.

BOART LONGYEAR

INVESTIGATION REPORT

MISHAP

Company	Division	Department	WCB Ref. No.

Type of Mishap (multiple selection(s) possible):

Injury			Property Damage / Loss to Process			Incident (potential loss)		
A	First Aid	☐	1	Equipment/Property Damage	☐	1	Injury	☐
M	Medical Aid Only	☐	2	Fire	☐	2	Equipment/Property Damage	☐
L	Lost Time	☐	3	Loss to Process	☐	3	Loss to Process	☐
F	Fatal	☐	4	Environment	☐	4	Environment	☐

Name of Injured Payroll No.	Describe Loss	Describe Potential Loss

Describe Injury

Location of Mishap	Date of Mishap Time:	Date Reported Time:

DESCRIPTION

Describe how the mishap occurred; include what the person(s) was doing, trying to do and anything unusual

Is there a written job procedure for the job being performed? Yes ☐ No ☐ N/A ☐

Identify equipment/material 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 > $10,000 < $100,000	Medical aid injury only or property damage > $1,000 < $10,000	First aid injury only or property damage < $1,000
Frequent	A ☐	D ☐	G ☐	J ☐
Occasional	B ☐	E ☐	H ☐	K ☐
Rare	C ☐	F ☐	I ☐	L ☐

Supervisor	Investigator	Date
Worker Representative	2nd Line Supervisor	Department Head

Comments

STATISTICS

Name of Injured	Payroll No	Sex	Age	Hire Date	WCB Ref. No
Occupation (at time of injury)				Regular ☐ Relief ☐ Temporary ☐	
Experience in occupation	0 - 6 mo ☐ 7 - 12 mo ☐ 1 - 2 yr ☐ 3 - 5 yr ☐ 6 - 10 yr ☐ 11 - 15 yr ☐ > 15 yr ☐				
Identify Common Core program for which injured is accredited	Mine ☐ Mill ☐ Diamond Drill ☐ Supervisor ☐				
Identify MSHA Training program for which injured is accredited	Surface ☐ Underground ☐ Coal ☐				

What training had been given in the safe performance of the task (multiple selection possible)?

Apprenticeship ☐ Common Core Modules ☐ Task Training ☐ Specialty Modules ☐ Specify

WHMIS ☐ Other ☐ Specify | Not Applicable ☐ Not Trained ☐

At time of mishap, employee was on: Individual/small crew incentive ☐ Company/department incentive ☐ Not on incentive ☐

Shift Time	**Shift Type**		**Overtime Shift**	
Start	Steady	☐	Overtime Hours	☐
Stop	Rotating	☐	Not Overtime	☐

How many complete shifts have been worked since the last 24 hour break from work?

FIRST AID

Describe injury (nature of injury and part(s) of body):

Number of persons requiring outside medical attention as a result of this mishap:

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 (MM/DD/YY)	First Aid Attendant (Name)

DOCTOR

Name of Doctor	
Address of Clinic or Hospital	Phone

TEAM

Investigation Team Memebers	Date of Investigation

REVIEW

Health & Safety Committee Rep (Union Rep)

Signature	Date

Health & Safety Commiteee Rep (Company Rep)

Signature	Date

Department Head

Signature	Title	Date

Manager

Signature	Title	Date
(Injured) Worker		
Signature		Date

Accident Investigation

Location where accident occurred		Employer's Premises: Yes ☐ No ☐ Job site: Yes ☐ No ☐	Date of accident or illness
Who was injured?		☐ Employee ☐ Non-Employee	Time of accident a.m. ☐ p.m. ☐
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred?
What property/equipment was damaged?			Property/equipment owned by:
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?			
How did injury/illness occur? List all objects and substances involved.			
Part of body affected/injured?		Any prior physical conditions? If so, what? Yes ☐ No ☐	
Nature and extent of injury/illness and property damaged (be specific)			

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

____ Improper instruction	____ Failure to lockout	____ Unsafe arrangement or process
____ Lack of training or skill	____ Unsafe position	____ Poor ventilation
____ Operating without authority	____ Improper dress	____ Improper guarding
____ Horseplay	____ Improper protective equipment	____ Improper maintenance
____ Physical or mental impairment	____ Unsafe equipment	____ Inoperative safety device
____ Failure to secure	____ Poor housekeeping	____ Other _____

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? ... Yes ___ No ___

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? ..... Yes ___ No ___

Did employee promptly report the injury/illness? ..... Yes ___ No ___

Is there modified duty available? ..... Yes ___ No ___

Supervisor's name	Supervisor's signature	Phone#	Date

Risk Rating Matrix

Severity of Consequences

Catastrophic- Death, permanent total disability or property damage > $100,000
Major- Lost time injury or property damage > $10,000 < $100,000
Minor- Reportable injury, no lost time or property damage > $1,000 < $10,000
Negligible- Minor medical treatment or property damage < $1,000

Priority Rating

A – First
B – Second
C – Third
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 REPORT FORM

Step 1- Completed by worker.

Date of Report: _____

Name of Worker: _____

Department: _____

Name of Supervisor Reported To: _____

Description of Hazard: _____

_____

_____

_____

Suggested Corrective Action (if any): _____

_____

_____

Step 2- Completed by supervisor.

Date of Response: _____

Name of Supervisor (if different from above): _____

Supervisor Response: _____

_____

_____

_____

ADVANCED EXPLORATIONS INCORPORATED

WEEKLY SAFETY MEETING

Date:

Attended by:

Job Name:
Time Started:
Time Finished:
Site Supervisor:
Site Supervisor's Signature:

	SAFETY TOPIC	**Action Responsibility and Target Date**
1		
2		
3		
4		
5		
6		
7	**Non Safety Issues:**	
8		
9		
10		

Suggestions made:
New Business:

Tailgate Safety Meeting

(Use to record any impromptu gathering)

Group Name: **Date:**

Persons in Attendance: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

General Topics Covered: _____

_____

_____

_____

_____

_____

Group Leader Signature: _____

(Turn in to Site Supervisor)

DAILY ON-SITE REPORT ROCHE BAY 2008

Date:		Site Supervisor:			
Camp Manager:		Drill Foreman:			
Total Camp Capactiy:		Drill Crew:			
People In:					
People Out:					
Total Camp Hours:		Water Meter Reading:			
Weather:					
Fuel Movement: _____ JetB _____ Diesel _____ Gas _____ Propane _____ Calcium					
Flight Hours:		Flight Fuel Usage (L):		Days:	
Accidents / Safety Issues:					
Daily Scoop:	-				
Notes for Tomorrow:	-				

5 POINT SAFETY SYSTEM CHECKLIST

5 POINT SAFETY SYSTEM CHECKLIST

1. Check entrance and travelway.

Ground conditions? _____

Ground support? _____

Travelway 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? _____

Guards/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?

SAFE PRODUCTION
5 POINT SAFETY SYSTEM

"A program of orderliness - carried out by supervision and individual employees - can bring big reductions in accidents, stores inventories and wasted time and energy."

1. Are the entrances and the travel way to your work place in good order? _____

2. a) Is your work place in good condition? _____

   b) Is your equipment in good condition? _____

3. Are you working properly? (proper tools, standard procedures, etc...)

   Yes _____ No _____

   If "NO" then explain and outline corrective action taken _____

   _____

4. Do an act of **SAFETY** (Comment and check list below) _____

   _____

5. 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 Check List: YES ✔ NO ✗	DR	HP	SPV
1. I understand today's job.			
2. I have and will use my P.P.E.			
3. I have tagged-in and reported to my supervisor.			
4. Are the entrances and travel ways to my work site in good order?			
5. Is the workplace and equipment in good order and safe?			
6. Can the work be done safely?			
7. I will work safely.			
8. I shall take care and watch out for my fellow workers.			
9. I will leave my my work site clean.			
10. I will tag-out and report to my supervisor at the end of the shift.			

BOART LONGYEAR INC. UNDERGROUND
Contract Drilling Services

DAILY SAFETY PRODUCTION REPORT

"The sure result of order is greater and safer production of better products at lower costs. Improved production and costs mean increased business and prosperity for any organization and its employees."

DATE: _____ SHIFT: Day Night

WORK AREA: _____

DRILLER: _____ HELPER: _____

DAILY WORK INSTRUCTIONS: _____

_____

TOOLS & MATERIAL: (Employee to report **all** Lost & Used Material)

_____

_____

FUEL AT SITE: _____

OIL AT SITE: _____

BITS AT SITE: _____

CORE BOXES AT SITE: _____

CALCIUM AT SITE: _____

DRILLER: _____ (Signature) HELPER: _____ (Signature)

SUPERVISOR: _____ (Signature)

TIME OF VISIT: _____