APPENDIX A

ADVANCED EXPLORATIONS INC.
JOB SAFETY ANALYSIS FORM

Title of job / Operation: | Date: | Page | of | JSA 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

ADVANCED EXPLORATIONS INC.

Job Safety Analysis Form

ame of Organisation Completing the Work:	Job Name:
ısk:	Job Number:
incipal Contractor:	Job Location:
ate the JSA was prepared:	Number of pages in this JSA:
ıis JSA has been reviewed by:	This JSA has been discussed with:
incipal Contractor of Representative (signature):	Employee/subcontractor (signature):
osition: Date:	Position: Date:

em 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)

em 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)

ADVANCED EXPLORATIONS INC.

ADVANCED EXPLORATIONS INC.
BEHAVIOR BASED SAFETY
OBSERVATION FORM

Date: _____ Observer: _____ Location: _____

Duration: _____ Name of Employee(s): _____

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

Use a ☑- mark to indicate each Safe Behavior, and a ☒-mark to record each At-Risk Behavior in the space provided. Briefly describe the At-Risk Behaviors observed and the Safe Behaviors of note in the comments section.

COMMUNICATION	☑ or ☒	WORK HABITS / BODY ACTIONS	☑ or ☒
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		Overexertion	
Description			
Description			

COMMENTS:

ADVANCED EXPLORATIONS INC.

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 treetment.

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 | Code

Date of Birth: (yyy / mm / dd) | **Married / Single:**

Date of Hire: (yyy / mm / dd) | **Rate of Pay:** $ | **per** (hr / day / mo)

Date of Injury / Onset of Illness: (yyy / mm / dd) | **Time:** | 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 | Code

Type of treatment:

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: (yyy / mm / dd) | **Supervisor's Signature:**

Woker'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:** _____

ADVANCED EXPLORATIONS INC.

ADVANCED EXPLORATIONS INC.
WEEKLY SAFETY MEETING

Date:	

Attended by:

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

Safety Topic

	Discuss:	**Action Responsibility and Target Date**
1	**Health and Safety Committee**	
1.1	Members of Management appointed (and Job Title):	
2		
3		
4		
5		
6		

7		
8		
9		
10		

Review Recent Accidents:

Suggestions made:

New Business:

ADVANCED EXPLORATIONS INC.

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

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 ☐	D ☐	G ☐	J ☐
Occasional	B ☐	E ☐	H ☐	K ☐
Rare	C ☐	F ☐	I ☐	L ☐

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
☐	☐	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 equipment, tools 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 P.P.E. properly	☐	☐	29	Hazardous environmental conditions: gases, dust, smoke, fumes, vapours
☐	☐	10	Improper loading	☐	☐	30	Noise exposure
☐	☐	11	Improper placement	☐	☐	31	Radiation exposure
☐	☐	12	Improper lifting	☐	☐	32	High or low temperature exposure
☐	☐	13	Improper position for task	☐	☐	33	Inadequate or excessive illumination
☐	☐	14	Horseplay	☐	☐	34	Inadequate ventillation
☐	☐	15	Inluence of alcohol or drugs	☐	☐	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 substandardactions 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 maitenance
☐	☐	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 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	☐	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

INFORMATION

Employee postal address:

Social insurance number:

Date of birth:

Contract start date:

Employment start date:

Office use only:

ADVANCED EXPLORATIONS INC.

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 ☐ Relief ☐ Temporary ☐	
Experience in occupation:	0-6mo ☐ 7-12mo ☐ 1-2yr ☐ 3-5yr ☐ 6-10yr ☐ 11-15yr ☐ >15yr ☐				
Identify common core program for which injured is accredited:	Mine ☐ Mill ☐ Diamond drill ☐ Supervisor ☐				
Identify MHSA Training program for which the injured is accredited:	Surface ☐ Underground ☐ Coal ☐				
What training had been given in the safe performance of the task? (multiple selections possible):					
Apprenticeship ☐ Common Core Modules ☐ Task Training ☐ Specialty Modules ☐ Specify					
WHMIS ☐ Other ☐ Specify			Not Applicable ☐ Not Trained ☐		
At time of incident, employee was on:	Individual/Small Crew Incentive ☐ Company/Department Incentive ☐ Not on Incentive ☐				

Shift Tme	Shift Type		Overtime Shift	
Start	Steady	☐	Overtime Hours	☐
End	Rotating	☐	Not Overtime	☐

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.

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
Neglegible - Minor medical treatment or property damage < $1,000	D - Fourth

Hazard:

Probability of Occurrence	Severity of Consequences			
	Catastrophic	Major	Minor	Neglegible
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	Neglegible
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	Neglegible
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	Neglegible
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.

ADVANCED EXPLORATIONS INC.
SAFE PRODUCTION
HAZARD REPORT FORM

Date: _____

Person Reporting the Hazard:

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:** _____

ADVANCED EXPLORATIONS INC.

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.

ADVANCED EXPLORATIONS INC.
SAFE PRODUCTION
5-POINT SAFETY SYSTEM

Daily Safety Production Report

Date:	Shift: Day ☐	Night ☐	
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:

1. Are the entrances and the travel way to your workplace in good order?
2. a) Is your workplace in good order?
   b) Is your equipment in good condition?
3. 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?

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 Checklist: Yes ☑ No ☒	Team member 1	Team member 2	Team member 3	Supervisor
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 travelways to my worksite 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 look out for my fellow workers.	☐	☐	☐	☐
9. I will leave my work site clean.	☐	☐	☐	☐
10. I will tag out and report to my supervisor at the end of my shift.	☐	☐	☐	☐

Signatures:

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

ADVANCED EXPLORATIONS INC.

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?**

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 *WSCC Claim: Employer's Report of Injury* 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 *WSCC Claim: Employer's Report of Injury* form. Worker completes and submits *WSCC Claim: Worker's Report of Injury* 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 *WSCC Claim: Employer's Report of Injury* form. Worker completes and submits *WSCC Claim: Worker's Report of Injury* 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 *Incident of a Serious Nature* above.	If the incident is deemed a dangerous occurance: - 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.

WSCC Workers' Safety & Compensation Commission

WSCC 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	Community	Postal Code
7. Residential Address (if different than above)	8. Date of Birth YY / MM / DD	9. Male ☐ Female ☐
10. Telephone (Include Area Code)	Cell	Email Address
11. Social Insurance Number	12. Single ☐ Married ☐ Common-Law ☐ Widowed ☐ Divorced ☐	
13. Number of Dependants	14. Worker's Occupation	15. Is a job description available? Yes ☐ No ☐
16. Does the worker work in more than one Province/Territory for this employer? ☐ Yes If yes, please list the Provinces/Territories: ☐ No	17. Is the worker a subcontractor? Yes ☐ No ☐ 18. Is the worker an owner or operator? Yes ☐ No ☐	

C – Incident Details

19. Place of Incident – Name of City/Town	Province/Territory	
20. Incident Date YY / MM / DD Time: AM / PM	Date first reported to Employer YY / MM / DD Time: AM / PM	Date first disabled from work YY / MM / DD
21. Did incident occur on employer's premises? Yes ☐ No ☐ If no, where?		
22. Does the worker have a job to return to? Yes ☐ No ☐ *If no, please attach an explanation*		
23. Was first aid provided? Yes ☐ No ☐ By whom:	24. Was any other treatment sought by worker? Yes ☐ No ☐	
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 ☐ No ☐ *If no, please attach an explanation*	
27. Is the activity part of the worker's regular work? Yes ☐ No ☐ *If no, please attach an explanation*	28. Are you satisfied that the incident occurred as reported? Yes ☐ No ☐ *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 ☐ No ☐ *If yes, please attach an explanation*	
32. Is light duty available? Yes ☐ No ☐ Has light duty been offered to the worker? Yes ☐ No ☐ When? YY / MM / DD *Please provide a list of light duties offered*	
33. Has worker returned to work? Yes ☐ No ☐ When? YY / MM / DD Worker returned to: Regular duties ☐ Light duties ☐	
34. If worker has lost time from work, please provide the date the worker first lost time. YY / MM / DD	35. If time was lost, and worker has since returned, please provide the date worker returned to work. YY / MM / DD

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	B) Non - Permanent
Type of Permanent Employment -	☐ Term (*Over 1 year*) ☐ Full / Part time Permanent ☐ Apprentice ☐ Relief ☐ Other	*Type of Non-Permanent Employment -* ☐ Term (*Under 1 year*) ☐ Seasonal ☐ Summer Student ☐ Casual ☐ Apprentice
37. Is the job subject to lack of work layoffs? Yes ☐ No ☐		38. Is the job subject to seasonal layoffs? Yes ☐ No ☐
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? _____ *If the worker is paid other than hourly or on salary, please attach an explanation.*	
47. Does the worker receive any other benefits? Yes ☐ No ☐ **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 ☐ No ☐	
49. Provide an estimate of regular overtime hours _____ / *Please circle one* day week month	50. What is the overtime rate? _____ / hr
51. Are you paying the worker for lost time? Yes ☐ No ☐	52. Will you continue to pay benefits? Yes ☐ No ☐ *(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

Ce formulaire est disponible en français
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WSCC Workers' Safety & Compensation Commission | ᐃᓄᓕᒫᓄᑦ ᐊᑦᑕᓇᖅᑐᓕᕆᓂᖅ ᐊᑭᓕᖅᓱᐃᓂᕐᓗ

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 YY / MM / DD	8. Male ☐ Female ☐

9. Telephone (Include Area Code)	Cell	Fax	Email Address

10. Social Insurance Number | 11. Single ☐ Married ☐ Common-Law ☐ Widowed ☐ Divorced ☐

12. Number of Dependants	13. Job Title	14. Preferred Language ☐ English ☐ French ☐ Inuktitut ☐ Other

B – Employer Information

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

C – Incident Details

19. Date of Incident YY / MM / DD Time: AM / PM	20. Place of Incident – Name of City/Town

21. Did incident occur on employer's premises? Yes ☐ No ☐ If no, where?

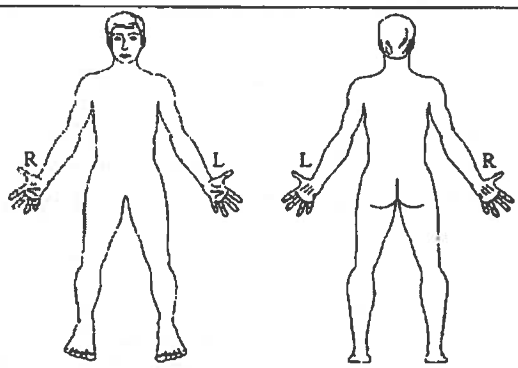
22. Date reported to employer YY / MM / DD Time: AM / PM	23. Name and position of person you reported incident to:
24. Date first disabled from work YY / MM / DD Time: AM / PM	

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 ☐ No ☐ When? YY / MM / DD

28. Have you returned to work? Yes ☐ No ☐ When? YY / MM / DD
If yes, ☐ Light Duties ☐ Regular Duties

29. Name of Attendant if first aid was provided? Where? When? YY / MM / DD

30. What Hospital / Health Care Centre did you go to? When? YY / MM / DD

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 ☐ No ☐ When? YY / MM / DD

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	B) Non - Permanent
	Type of Permanent Employment - ☐ Term (*Over 1 year*) ☐ Full / Part time Permanent ☐ Apprentice ☐ Relief ☐ Other	*Type of Non-Permanent Employment* - ☐ Term (*Under 1 year*) ☐ Seasonal ☐ Summer Student ☐ Casual ☐ Apprentice
35. Is the job subject to seasonal layoffs? Yes ☐ No ☐		36. Is the job subject to lack of work layoffs? Yes ☐ No ☐
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 What is your annual gross earnings? _____

If you are paid other than hourly or on salary please attach an explanation

44. Do you receive any other benefits? Yes ☐ No ☐ **If yes, explain in detail with amounts or averages:**
(eg: Vacation pay, Northern Allowance, Bonus)

45. Do you regularly work or get paid for overtime? Yes ☐ No ☐

46. Provide an estimate of regular overtime hours _____ / *Please circle* day week month	47. What is your overtime rate? _____ / hr

48. Are you being paid for lost time? Yes ☐ No ☐

49. Do you have a second job? Yes ☐ No ☐ If yes, have you missed time from this job due to your injury? Yes ☐ No ☐
(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
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www.wscc.nt.ca or www.wscc.nu.ca

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APPENDIX C

ADVANCED EXPLORATIONS INC.

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.

ADVANCED EXPLORATIONS INC.

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.

Procédure d'évacuation en cas d'urgence médicale

Évacuation par hélicoptère

1. Les personnes sur la scène devront appeler pour l'aide selon n'importe moyen disponible (radio, « sat phone », etc.). « Help, help, help, emergency, emergency, emergency. » (A ce moment, tout communication par radio est réserver pour le médique, le foreman, et le superviseur de site).
2. Le médique sera envoyer selon la moyenne la plus efficace, soit :
    a. Hélicoptère si site est a un distance; ou
    b. Quad ou Ranger si cela serait plus vite.
3. Au besoin, le foreman ferait 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 envoyer à la scène avec d'autre équipement selon les besoins du médique.
5. Si l'hélicoptère n'est pas déjà sur scène, elle sera envoyer 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 personnes impliquées devront rencontrer le superviseur de site aussitôt que pratique pour compléter un rapport de l'incident.

Évacuation au cas ou l'hélicoptère ne peut pas voler

1. Les personnes sur la scène devront appeler pour l'aide selon n'importe moyen disponible.
2. Le paramedical et un secouriste seront envoyer sur scène selon le moyen le plus efficace, soit le « Quad, » « Ranger », « Snowmobile », etc.
3. Le foreman et un autre secouriste seront envoyer avec un machine de neige équiper d'un « stretcher » et « backboard ».
4. Tout les sites devraient être à l'écoute pour un instruction d'arrêt de travail, de plus d'amples informations ou de demandes d'aide.
5. Le paramédical déplacerait 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 serait assister à établir le communication avec un facilité médical pour avoir l'assistance d'un médecin.
9. Le blessé serait évacuer aussitôt que les conditions le permet.

- 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 cook). Pourtant, nous avons engagé un paramédical en vu de notre location particulière. Au cas que le paramédical devrait accompagner le blessé à Hall Beach, le travail continuerai 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 securitaire.

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

APPENDIX D

ADVANCED EXPLORATIONS INC.

Advanced Explorations Inc.
Emergency Contact Numbers

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

APPENDIX E

ADVANCED EXPLORATIONS INC.

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 manditory.
	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.

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					

ADVANCED EXPLORATIONS INC.

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:

ADVANCED EXPLORATIONS INC.

Orientation Sign-Off Sheet

Camp:

Date:

Names (Signature):