Investigation Report

Revised 04JUN96

Department | Number

MISHAP

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 | Describe loss | Describe potential loss

Describe injury | Estimated PONC | Actual PONC

Location of mishap *(be specific)*

mm/dd/yy

Date of mishap: _____ Time _____ ___ a.m ___ p.m

Date reported: _____ Time _____ ___ a.m ___ p.m

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)

EVALUATION

Circle the one letter which best identifies the loss potential if hazard(s) are not eliminated or controlled.

POTENTIAL SEVERITY

PROBABILITY OF 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

NOTE: ALL FIRES MUST BE FULLY INVESTIGATED

Supervisor _____ Investigator _____ Date _____

Signature | Signature

ACTION

Loss Control Department _____ / / Worker _____ Department Head _____

Signature | Date(mm/dd/yy) | Signature | Signature

Comments:

Routing: Investigator > 2nd Line Supervisor > Department Head > Loss Control > Assistant Manager > General Manager

Copies to: OH&SC Supervisor General Manager Other

DIRECT CAUSE/IMMEDIATE ACTION

Identify the substandard action(s) and condition(s) that caused or could have caused this mishap.
Explain selections in the space below.

	Code	SUBSTANDARD ACTIONS
☐	30	Operating equipment without authority
☐	31	Failure to warn
☐	32	Failure to secure/make safe
☐	33	Operating at improper speed
☐	34	Making safety devices inoperable
☐	35	Removing safety devices
☐	36	Using defective equipment
☐	37	Using equipment improperly
☐	38	Failure to use personal protective equipment properly
☐	39	Improper loading
☐	40	Improper placement
☐	41	Improper lifting
☐	42	Improper position for task
☐	43	Servicing equipment in operation
☐	44	Horseplay
☐	45	Influence of alcohol/drugs

	Code	SUBSTANDARD CONDITIONS
☐	50	Inadequate guards or barriers
☐	51	Inadequate ground support
☐	52	Inadequate/improper protective equipment
☐	53	Defective tools, equipment or materials
☐	54	Congestion or restricted action
☐	55	Inadequate warning system
☐	56	Fire and explosion hazards
☐	57	Substandard housekeeping
☐	58	Hazardous environmental conditions: gases, dusts, smoke, fumes, vapours
☐	59	Noise exposure
☐	60	Radiation exposure
☐	61	High or low temperature exposures
☐	62	Inadequate or excessive illumination
☐	63	Inadequate ventilation
☐	64	Ground (rock) conditions

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

BASIC/UNDERLYING CAUSE

Identify the reasons for the existence of the substandard actions and conditions selected above by marking each factor. Give the basic/underlying cause for each selected immediate/direct cause and explain in the space below.

	Code	PERSONAL FACTORS
☐	70	Inadequate physical/mental capability
☐	71	Lack of knowledge
☐	72	Lack of skill
☐	73	Stress physical or mental
☐	74	Improper Motivation

	Code	JOB FACTORS
☐	80	Inadequate leadership/supervision
☐	81	Inadequate engineering
☐	82	Inadequate purchasing
☐	83	Inadequate maintenance
☐	84	Inadequate tools/equipment
☐	85	Inadequate work standards
☐	86	Wear and tear
☐	87	Abuse or Misuse

Immediate/ direct code	Basic/ Underlying Code(s)	How does the immediate/direct cause stem from the basic/underlying cause?

LACK OF 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 ☐
- Inadequate program standards ☐
- Inadequate compliance to program standards ☐

ACTION TAKEN

What immediate action has already been taken to prevent a similar occurrence.

Cause Code(s)	By whom	Date

What action is recommended to be taken to prevent and/or control a similar occurrence.

Cause Code(s)	Responsibility	Date to be Completed

SKETCH

Sketch, diagram and/or additional notes.

Injury code	Class number	Contact code	Sex	Age	Hire date	WCB Claim #

Occupation *(at time of mishap)* _____ 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 ☐

What training has been given in the safe performance of the work *(more than one may apply)*

1. ☐ Apprenticeship
2. ☐ Lupin trainer/operator *(specify)* _____
3. ☐ Other Lupin training program *(specify)* _____
4. ☐ WHMIS
5. ☐ Other *(specify)* _____
6. ☐ Not applicable
7. ☐ No training

Shift time

Start _____ ☐ a.m. ☐ p.m.

Stop _____ ☐ a.m. ☐ p.m.

Shift type

Steady ☐ Rotating ☐

Overtime shift ☐ Overtime hours ☐ Not overtime ☐

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

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 14+

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

To your knowledge, has the worker had a previous similar disability? Yes ☐ No ☐

Has modified work been assigned? Yes ☐ No ☐ **Describe:** _____

Investigation team members	Date of investigation

Worker: _____

_____ Signature _____ Date _____

Other (Maint., Eng., etc.): _____

Signature _____ Title _____ Date _____

Other (OH&SC): _____

Signature _____ Title _____ Date _____

2nd Line: _____

Signature _____ Date _____

Department Head: _____

Signature _____ Title _____ Date _____

Loss Control Department: _____

_____ Signature _____ Date _____

Assistant Manager: _____

_____ Signature _____ Date _____

Manager: _____

_____ Signature _____ Date _____

IMMEDIATE/DIRECT CAUSES - STANDARD ACTIONS

General Examples (Keep in mind these causes deal with the actions of people)

30 Operating without authority	Situations where special rules, special permits or skill training are required.
31 Failure to warn	People, including supervisors, are aware of a dangerous condition, but fail to advise other people and/or management.
32 Failure to secure/make safe	Not shutting down or preventing access to hazardous or improperly operating equipment or area, not locking-out electrical or operating equipment, not scaling rock (mining).
33 Operating at improper speed	Driving vehicles or operating other equipment outside of design or prescribed limits. Includes running and hurrying to complete the job.
34 Making safety devices inoperable	Causing guards, barriers, governors or warning devices in place not to operate as designed (could be more dangerous than removing a device since others may believe it would operate properly if there).
35 Removing safety devices	Removing guards, barriers, warning devices.
36 Using defective equipment	Continuing to use hazardous, poorly operating equipment known to be defective.
37 Using equipment improperly	Not using the equipment the way it was supposed to be used.
38 Failure to use PPE properly	Self-explanatory.
39 Improper loading	Loading materials incorrectly either in number, sequence, distribution or size in vehicles, equipment or storage areas.
40 Improper placement	Placing equipment and/or materials in a hazardous or disruptive position.
41 Improper lifting	Causing injury to the person doing the lifting, injury to other people, damaging property or interrupting process through an improper lifting technique.
42 Improper position for task	People taking a position so as to cause injury, damage to property or loss to process; loss could result from one particular event or over a period of time.
43 Servicing equipment in operation	Attempting to repair, service or adjust equipment while it is operating.
44 Horseplay	Any activity not part of the normal routing of work which creates a disruptive or hazardous situation, usually done for "fun" or to ease boredom.
45 Influence of alcohol/drugs	Includes over-the-counter and prescription drugs, controlled substances and uncontrolled substances.

IMMEDIATE/DIRECT CAUSES - SUBSTANDARD CONDITIONS

General Examples (Deals primarily with physical, mechanical or environmental conditions)

50 Inadequate Guards or Barriers	Includes guards or barriers which do not provide the needed protection or are not in place.
51 Inadequate ground support	Insufficient number to rock bolts or other means of ground support. Ground support should have been installed but wasn't.
52 Inadequate or Improper PPE	Includes PPE not made available or which does not provide needed protection.
53 Defective tools, equipment or material	Could be defective through normal wear and tear, misuse and/or abuse or inadequate design or materials.
54 Congestion or restricted action	People, materials or equipment in a space or area inadequate for their safe or efficient operation.
55 Inadequate Warning system	Includes communication of warnings and coverage of required areas (eg: signs, labels, colour-coding, available warnings and lights).
56 Fire and Explosion Hazards	Self-explanatory.
57 Substandard housekeeping	Includes presence of contaminants or other substances eg. slippery substances on floor which should have been cleaned up; unnecessary items, inefficiency in the availability of tools, materials and equipment.
58 Hazardous environmental conditions: dust, gases, smoke, fumes, vapours	Includes chemical, biological (insects, animals, plants, bacteria, viruses, fungi, etc.)
59 Noise exposure	Noise levels which can injure or cause stress to people, equipment or materials, including exposure over an extended period; noise levels which interfere with communication or recognition of necessary auditory signals.
60 Radiation exposure	Radiation levels (ionizing or non-ionizing, such as light or heat) which can injure or cause stress to people, equipment or materials, including exposure over an extended period.
61 Temperature extremes	Hot or cold, indoors or outdoors, sudden or over an extended period (includes air, equipment and material temperature), could cause damage or stress.
62 Inadequate or excessive illumination	Deals with light adequate to function or perform an task.
63 Inadequate ventilation	Includes natural or mechanical ventilation which supplies sufficient oxygen and protects against airborne contaminants or gases (for example, carbon monoxide).
64 Ground conditions	In the mine environment, created by poor blasting practices, poor engineering practices, geological features.

Table III ....

BASIC/UNDERLYING CAUSES OF MISHAPS

PERSONAL FACTORS

70 INADEQUATE PHYSICAL/MENTAL CAPABILITY

PHYSICAL

- Physical appropriate height, weight, size, strength, etc.
- restricted range of body movement
- limited ability to sustain body positions
- substance sensitivities or allergies
- vision or hearing deficiency
- other sensory deficiency (touch, taste)
- respiratory incapacity
- other physical disabilities

MENTAL

- fears and phobias
- emotional disturbance
- inability to comprehend
- poor judgement or coordination
- slow reaction time
- low mechanical aptitude or learning aptitude
- memory failure

71 LACK OF KNOWLEDGE

- inadequate orientation, training & update training
- lack of experience
- misunderstood directions

72 LACK OF SKILL

- inadequate initial instruction
- inadequate practice
- infrequent performance
- lack of coaching

73 STRESS

MENTAL

- emotional overload
- routine, monotony, uneventful, meaningless activities
- fatigue due to mental task load or speed
- extreme judgement/decision demands
- extreme concentration or perception demands
- confusing directions, conflicting demands
- preoccupation with problems, frustration

PHYSICAL

- fatigue due to task load, duration, lack of rest
- fatigue due to sensory overload
- exposure to health hazard or temperature extremes
- constrained movement
- drugs
- injury or illness

74 IMPROPER MOTIVATION

- improper performance is rewarding
- proper performance is punishing
- lack of or improper incentives
- excessive frustration
- improper supervisory example
- inappropriate aggression
- improper attempt to save time or effort, avoid discomfort
- improper attempt to gain attention
- inappropriate peer pressure

Table III cont'd ....

BASIC/UNDERLYING CAUSES OF MISHAPS

JOB FACTORS

80 INADEQUATE LEADERSHIP &/OR SUPERVISION

- instructions, orientation &/or training
- identification & evaluation of loss exposures
- work planning or programming
- matching of qualifications & job task requirements
- performance measurement & evaluation
- inadequate or incorrect performance feedback
- unclear/ conflicting reporting relationships
- unclear or conflicting assignment of responsibility
- improper or insufficient delegation
- give inadequate policy, procedure, practices or guide lines
- give objectives or standards that conflict
- lack of supervisory/management job knowledge

81 INADEQUATE ENGINEERING

- consideration of human factors/ergonomics
- standards, specifications &/or design criteria
- monitoring of construction, or initial operation
- assessment of operational readiness

82 INADEQUATE PURCHASING

- improper salvage &/or waste disposal
- specification on requisitions, or to vendors
- research on materials/equipment
- mode or route of shipment, inspection & acceptance
- transportation, handling/storage of materials
- communication of safety & health data
- identification of hazardous items

83 INADEQUATE MAINTENANCE

- communication of needs, scheduling of work
- examination of units, part substitution
- preventive assessment of needs, lubrication & servicing
- reparation, adjustment/assembly, cleaning or resurfacing

84 INADEQUATE TOOLS/EQUIPMENT

- assessment of needs & risks
- human factors/ergonomics considerations
- standards or specifications
- adjustment, repair, removal, replacement & maintenance
- availability

85 INADEQUATE WORK STANDARDS

- standards' development, communication & maintenance
- inconsistent standards, procedures' & rules
- inventory & evaluation of exposures & needs
- coordination with process design
- employee involvement
- updating
- publication, translation, distribution
- training, reinforcing signs, colour codes, & job aids
- tracking of work flow
- monitoring use of standards, procedures' & rules

86 WEAR & TEAR

- improper extension of service life
- inadequate inspection &/or monitoring
- inadequate planning of use
- improper loading or rate of use
- use by unqualified people or for wrong purpose

87 ABUSE OR MISUSE

- condoned by supervision
  - intentional
  - unintentional
- not condoned by supervision
  - intentional
  - unintentional

EMERGENCY PROCEDURES - ULU

EMERGENCY INFORMATION SHEET:

DATE & TIME: _____

PATIENT NAME: _____

BIRTHDATE: _____

HEALTH CARE NUMBER: _____

SOCIAL INSURANCE NUMBER: _____

MEDICAL PROBLEM:

_____

_____

_____

_____

TREATMENT:

_____

_____

_____

_____

_____

MEDICAL HISTORY:

_____

_____

_____

_____

REFERRAL:

_____

NURSES' FIRST REPORT

WORKERS' COMPENSATION BOARD

NAME: _____ TYPE OF ACCIDENT: _____

DATE OF ACCIDENT: _____ DATE FIRST TREATED: _____

PAST HISTORY

Any significant previous disease or injury?

Worker presents with:

ASSESSMENT:

ARE DENTAL SERVICES REQUIRED? YES _____ NO _____

IS PERMANENT DISABILITY PROBABLE? YES _____ NO _____

IS HOSPITAL CARE REQUIRED? YES _____ NO _____

ESTIMATE PERIOD OF DISABILITY AS APPLICABLE:

O LAY OFF _____ LESS THAN 7 DAYS _____ 7-14 DAYS _____ MORE THAN 14 DAYS _____

INTERVENTION AND TREATMENT:

EVALUATION:

Do you think there is any misrepresentation or concealment in this case?

PLAN:

Where has the worker been referred? Hospital Name _____

Doctor's Name _____

ADDITIONAL COMMENTS:

NURSE'S SIGNATURE: _____ DATE: _____

WORKERS' COMPENSATION BOARD
Northwest Territories

EMPLOYER'S REPORT OF ACCIDENT

WCB Account Number

Complete all questions, sign and send to the WCB - Please print clearly

Employer's Name & Address - Include Postal Code

Type of industry

Phone Number - Include Area Code ( )

Worker's Name & Address - Include Postal Code

Phone Number - Include Area Code ( )

Name of city, town or place of accident

Province/Territory

Occupation

Was the worker on the employer's premises when the accident occurred? Yes ☐ No ☐ State exactly where the accident occurred

Social Insurance Number

Is the worker's employment secure when fit to return to work? Yes ☐ No ☐ If no, explain

Date of Birth Y M D

Accident Date Y M D Time AM ☐ PM ☐

Sex M ☐ F ☐ Marital Status Dependents

Accident first reported to employer Y M D Time AM ☐ PM ☐

Time worker commenced work on the day of accident Time AM ☐ PM ☐

Was First Aid rendered? Yes ☐ No ☐ When?

Name of Attendant

Name & Address of attending doctor or hospital

COMPLETE ALL QUESTIONS - Give full explanation - Attach extra sheets if necessary

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

   Were they part of the regular work? Yes ☐ No ☐

   Are you satisfied the injury occurred as reported? Yes ☐ No ☐

2. What happened to cause the injury?

   What was the worker doing?

   What machine, tool, equipment or material was the worker using?

   State any involvement of gas, chemical or extreme temperature

   Was language a contributing factor?

3. What part of the worker's body was injured? (Hand, eye, back, etc State right or left)

   What type of injury did the worker sustain? (Burn, fracture, bruise, etc.)

4. Is the worker related to the employer and living in the employer's house at the time of accident? Yes ☐ No ☐

   Is the worker a Partner, Director or other Officer of the company? If yes, specify Yes ☐ No ☐

   Does the worker employ his/her own workers? If yes, explain. Yes ☐ No ☐

   Was any person *not* in your employ to blame for or involved in the accident? If yes, explain Yes ☐ No ☐

5. Was the worker disabled longer than the date of accident? If yes, complete the questions on reverse Yes ☐ No ☐

REPORT THIS ACCIDENT TO WCB IMMEDIATELY

Ce dépliant est disponible en français.

6. Give the date and hour the worker was first disabled from work — Y / M / D / Time / AM / PM

Has the worker returned to work? Yes ☐ No ☐ — If yes, give the date and time the worker returned to work — Y / M / D / Time / AM / PM

Did the worker work between first disablement and final return? Yes ☐ No ☐ — If yes, give dates and times — From — Y / M / D / Time / AM / PM

To — Y / M / D / Time / AM / PM

Did you pay or allow worker anything for the period of disability? Yes ☐ No ☐ If yes, explain — Total amount

7. Usual working hours per day — From — AM ☐ PM ☐ To — AM ☐ PM ☐ — Specify usual days and hours in work week — Hours — Days

Specify amount of time off for lunch — Is worker paid for this time? Yes ☐ No ☐ — Circle usual days off: Mon Tue Wed Thu Fri Sat Sun

8. Rate of pay at the time of accident was $ — Hour ☐ Week ☐ Bi-Weekly ☐ Month ☐ Other - *Please explain*

Average monthly bonus $ — Overtime rate $

Does worker receive overtime on a regular basis? Yes No — Number of hours per Week / Month / Shift

How long has the worker been employed by you? From Year / Month / Day — To Year / Month / Day

State gross earnings of worker for the past 12 months. If less than 12 months, state gross earnings to-date — Gross Earnings

Does the worker normally receive any of the following benefits?			**Indicate which benefits you will continue to pay the worker while on compensation.**		
Shift Premium / Differential / Bonus	Yes ☐ No ☐	Amount	Yes ☐ No ☐	Amount	
Room and Board or Rent Subsidy	Yes ☐ No ☐	Amount	Yes ☐ No ☐	Amount	
Fuel / Cash Equivalent	Yes ☐ No ☐	Amount	Yes ☐ No ☐	Amount	
Tips / Gratuities	Yes ☐ No ☐	Amount	Yes ☐ No ☐	Amount	
Isolated Pay Allowance / Settlement Allowance	Yes ☐ No ☐	Amount	Yes ☐ No ☐	Amount	
Holiday Pay	Yes ☐ No ☐	Amount	Yes ☐ No ☐	Amount	
Other, Please Specify	Yes ☐ No ☐	Amount	Yes ☐ No ☐	Amount	
	TOTAL:	Amount	**TOTAL:**	Amount	

9. Is the worker's job subject to: Seasonal layoffs Yes ☐ No ☐ — Lack of work layoffs Yes ☐ No ☐ — If it was not for the accident, what would be the worker's last day of work? Year / Month / Day

Type of employment: ☐ Permanent ☐ Casual ☐ Summer Student ☐ Seasonal ☐ Apprentice ☐ Other — Please explain

What is the number of months a similarly employed worker would be employed in a 12 month period?

10. Please supply one complete shift cycle.

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

Number of days on — Number of days off — Date shift cycle commenced

IMPORTANT

Notification of accident ***MUST*** reach the Workers' Compensation Board office within three working days of occurrence or report of occurrence. Report by fax or delivery of this document by hand is recommended.

Employer's Name — Signed at *city, town, village*

Completed by — Authorized signature — Date

P.O. Box 8888 Yellowknife, NT X1A 2R3, Phone: (403) 920-3888, Toll Free: 1-800-661-0792, Fax: (403) 873-4596

WORKERS' COMPENSATION BOARD
Northwest Territories

WORKER'S REPORT OF ACCIDENT

Complete all questions, sign and send to the WCB - Please print clearly

For WCB Use Only

Employer's Name & Address - Include Postal Code

Phone Number - Include Area Code ( )

Workers' Name & Address - Include Postal Code

Phone Number - Include Area Code ( )

Name of city, town or place of accident | Province/Territory

Social Insurance Number | Occupation

Were you on the employer's premises when the accident occured? Yes ☐ No ☐ State exactly where the accident occurred

Date of Birth Y M D | Sex M ☐ F ☐ | Marital Status | Dependents

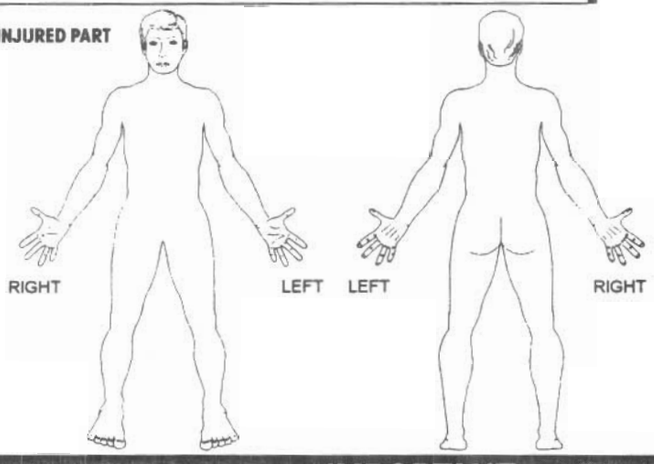
At the time of the accident, was the work you were doing for the purpose of your employer's business? Yes ☐ No ☐ Was it part of your regular work? Yes ☐ No ☐

	Y	M	D	Time	AM	PM
Accident Date					☐	☐
Date first disabled from work					☐	☐
When did you report the accident to your employer?					☐	☐

To whom did you report the accident?

1. How did the accident happen and what injury did you receive? **Be specific** (i.e. lifting, or, if you fell, how far did you fall? state right or left, if applicable). State how long you have been doing this work. Attach extra sheet(s) if necessary.

MARK INJURED PART



IMPORTANT - Please list any witnesses

Name & Address

Name & Address

2. Name of attendant if First Aid was provided. | Where? | When? Y M D

3. Name & address of attending physician/dentist | What hospital did you go to?

4. Have you had a similiar disability before? Yes ☐ No ☐ YES - Explain

Have you had previous claims with this Board? Yes ☐ No ☐ YES - Give dates and nature of injury

Have you had previous claims with other Boards? Yes ☐ No ☐ YES - Give name of Board, dates and nature of injury

5. Are you related to your employer? Yes ☐ No ☐ Were you living in your employer's house at the time of accident? Yes ☐ No ☐

Are you a partner, director or other officer of the company? Yes ☐ No ☐ YES - Specify

Do you employ workers yourself? Yes ☐ No ☐ YES - Explain

Are you an owner operator? Yes ☐ No ☐ YES - Explain

IF DISABLED LONGER THAN DATE OF ACCIDENT, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

REPORT THIS ACCIDENT TO YOUR EMPLOYER IMMEDIATELY

Ce dépliant est disponible en français.

6. Give the date and hour you were first disabled from work | Y | M | D | Time | AM ☐ PM ☐

Have you returned to work? Yes ☐ No ☐ If yes, give the date and time you returned to work | Y | M | D | Time | AM ☐ PM ☐

Did you work from your first disablement until your final return? Yes ☐ No ☐ If yes, give dates and times
From | Y | M | D | Time | AM ☐ PM ☐
To | Y | M | D | Time | AM ☐ PM ☐

Were you paid anything during your period of disability? Yes ☐ No ☐ If yes, explain | Total amount

7. Usual working hours per day From AM ☐ PM ☐ To AM ☐ PM ☐ | Specify usual days and hours in work week | Hours | Days

Specify amount of time off for lunch | Are you paid for this time? Yes ☐ No ☐ | Circle usual days off: Mon Tue Wed Thu Fri Sat Sun

8. Rate of pay at the time of accident was $ | Hour ☐ | Week ☐ | Bi-Weekly ☐ | Month ☐ | Other - *Please explain*

Average monthly bonus $ | Overtime rate $

Do you work overtime on a regular basis? Yes ☐ No ☐ | Number of hours per | Week | Month | Shift

How long have you been employed with this employer? From | Year | Month | Day | To | Year | Month | Day

State your gross earnings with this employer for the past 12 months. If less than 12 months, state your gross earnings to-date. | Gross Earnings

Do you have a second job? Yes ☐ No ☐ | Name of Company | Gross Earnings in the last 12 months

Do you normally receive any of the following benefits?	Yes	No	Amount	**Have you been paid any of these benefits while on compensation?** Yes	No	Amount
Shift Premium / Differential / Bonus	☐	☐		☐	☐	
Room and Board or Rent Subsidy	☐	☐		☐	☐	
Fuel / Cash Equivalent	☐	☐		☐	☐	
Tips / Gratuities	☐	☐		☐	☐	
Isolated Pay Allowance / Settlement Allowance	☐	☐		☐	☐	
Holiday Pay	☐	☐		☐	☐	
Other, Please Specify	☐	☐		☐	☐	
	TOTAL:		Amount	**TOTAL:**		Amount

9. Is your job subject to: Seasonal layoffs Yes ☐ No ☐ | Lack of work layoffs Yes ☐ No ☐ | If it was not for the accident, what would be your last day of work? | Year | Month | Day

Type of employment: ☐ Permanent ☐ Casual ☐ Summer Student ☐ Seasonal ☐ Apprentice ☐ Other | Please explain:

In the past twelve months, what other employment earnings or income did you receive?

Name of Company	From Year	Month	Day	To Year	Month	Day	Total Earnings
						TOTAL:	

10. *Please supply one complete shift cycle.*

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

Number of days on | Number of days off | Date shift cycle commenced

I declare, all the information I have given on this form is true and correct and I elect to claim compensation for the above mentioned injuries or disease. This will authorize the Board and boards of review to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to examination, treatment, history and employment of the undersigned. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation without advising the Board. *Failure to complete all sections, may result in a delay of the administration of my claim.*

Signed at | **Date** | **Signature**

EMERGENCY PROCEDURES - ULU

SURFACE/UNDERGROUND EMERGENCY CHECKLIST:

1. Record caller's name: _____
2. Caller's location _____
3. Nature of emergency _____
4. Location of emergency _____
5. Name of Injured/ill _____
6. Number of injured/ill _____
7. Types of injuries/illness _____
8. Time 1st call came in _____
9. Notify Nurse and Site Supervisor immediately
10. If mobilization or evacuation is required, notify the Surface Supervisor to have equipment and vehicles readied

INSTRUCT THE CALLER TO STAY WITH THE INJURED/ILL UNTIL HELP ARRIVES

EMERGENCY PROCEDURES - ULU

EMERGENCY INFORMATION SHEET:

DATE & TIME: _____

PATIENT NAME: _____

ADDRESS & PHONE #: _____

EMERGENCY NOTIFICATION: _____

BIRTHDATE: _____

HEALTH CARE NUMBER: _____

SOCIAL INSURANCE NUMBER: _____

ILLNESS / INJURY:

_____

_____

_____

_____

TREATMENT:

_____

_____

_____

_____

_____

MEDICAL HISTORY:

_____

_____

_____

REFERRAL:

_____

EMERGENCY PROCEDURES - ULU

HEALTH SERVICES CHECKLIST:

1. Report to Health Services Office _____

2. Inform Yellowknife Stanton Hospital @ 403-920-4111 of the situation (if required) _____

3. Prepare to go to site if required _____

4. If the number of casualties is greater than can be accommodated in the infirmary, have Camp Manager prepare beds or move mattresses to control area _____

5. Have necessary medical supplies moved to treatment location _____

6. Request help from other departments as required _____

7. As patient arrive, designate 'first aiders' and helpers to patient. If there are too many patients, key individuals should be given responsibility for a wing of 'first aiders' and patients _____

8. Assign responsible person to monitor the nursing station phone. Instruct that person not to make outside calls unless authorized by Nurse _____

9. Arrange medivac if required _____

EMERGENCY PROCEDURES - ULU

AVIATION EMERGENCY
HEALTH SERVICES CHECKLIST:

1. Report to Health Services Office _____
2. Radio operator will inform the number of passengers on downed aircraft _____
3. Inform Yellowknife Stanton Hospital @ 403-920-4111 of the situation (if required) _____
4. Inform MacKenzie Regional Health Services, patient referral, and advise of situation _____
5. Prepare to go to site if required _____
6. If the number of casualties is greater than can be accommodated in the infirmary, have Camp Manager prepare beds or move mattresses to control area _____
7. Have necessary medical supplies moved to treatment location _____
8. Request help from other departments as required _____
9. As patient arrive, designate 'first aiders' and helpers to patient. If there are too many patients, key individuals should be given responsibility for a wing of 'first aiders' and patients _____
10. Assign responsible person to monitor the nursing station phone. Instruct that person not to make outside calls unless authorized by Nurse _____
11. Arrange medivac if required _____

EMERGENCY PROCEDURES - ULU

SURFACE CREW CHECKLIST

Upon being notified by the Site Supervisor of an emergency situation, the following procedures will be followed:

1. The Surface Supervisor will designate a person to have the bus fueled and readied to transport persons as required
2. All pickups and necessary equipment will be fueled and will standby for further instructions
3. The surface crew will standby to deliver other supplies as required and to assist if needed
4. If requested, prepare emergency genset to be taken to the airstrip for lights etc.

EMERGENCY PROCEDURES - ULU

SWITCHBOARD OPERATOR CHECKLIST:

1. Check with Elect./Systems to verify the telephones have been put on Emergency mode

2. Monitor incoming telephone calls
   - direct calls for the Nursing Station only if related the emergency
   - direct all other calls to the Site Supervisor if related to the emergency

3. Do NOT release any information to outside parties regarding the emergency

4. Record names, phone numbers and times of all incoming calls related to the emergency

5. Record the time the emergency switchboard procedures were canceled (by the Site Supervisor only)

CALL RECORD SHEET: (Use back of sheet if more space is required)

Time:	Caller:	Phone #:	Message:

EMERGENCY PROCEDURES - ULU

REFUGE STATION CHECKLIST:

In the event of evacuation to a refuge station, the following procedures should be followed:

1. The first person to arrive at refuge station or person elected thereafter shall record the following information:

    a) each person's name

    b) time each person arrived in the refuge station

    c) each person's supervisor

2. Contact should be made with the control center as soon as possible

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

EMERGENCY PROCEDURES - ULU

CAMP MANAGER CHECKLIST

1. Contact control center to find out the number of persons injured/ill. In consultation with the Nurse - prepare to move mattresses and bedding as directed.

2. Prepare to have coffee, tea, juice and snacks to the control area

3. Post guard to prevent unnecessary people from entering the treatment area

4. Prepare meals as required

5. Assist as required