

JOB SAFETY & TRAINING

Minnesota Municipal Utilities Association

This program has been developed and
modified for use by:

Grand Rapids
Public Utilities

***AWAIR* —**

A Workplace Accident & Injury

Reduction Program

MMUA – JOB SAFETY & TRAINING

AWAIR Program

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Introduction

In 1990, the State of Minnesota amended the Occupational Safety and Health Act. Minnesota Statutes Chapter 182.653 subd.8 requires employers in certain industries to develop written, comprehensive workplace safety and health programs which are based on the NAICS (North American Industry Classification System) system. This legislation is known as A Workplace Accident and Injury Reduction (AWAIR) Act. Programs developed to comply with the act are known as AWAIR programs. The requirements of the legislation that are addressed and complied with in our program are as follows:

1. How managers, supervisors and employees are responsible for implementing the program and how continued participation of management will be established, measured, and maintained.
2. The methods used to identify, analyze and control new or existing hazards, conditions, and operations.
3. How the plan will be communicated to all affected employees so that they are informed of work-related hazards and controls.
4. How workplace accidents will be investigated, and corrective action implemented; and
5. How safe work practices and rules will be enforced.

MN OSHA has adopted a list of NAICS codes that we have determined to exist within our jurisdiction as a public entity. These departments are under our blanket AWAIR program. The NAICS codes for the departments under our AWAIR Program are highlighted on the listing in Appendix A.

Safety Policy Statement

Insert into this paragraph a safety policy statement agreed upon by the Safety Committee and Management.

Safety policy statement to be developed at a later date.

Approval/Revision of Program

The approval of this AWAIR Program is so recorded as such in the minutes of meeting dated **(Insert Date Here)**. Approving Authority for program is maintained by **(Insert Name of Approving Authority Here)** as so indicated by the previously stated recording in the meeting minutes.

The Safety Committee annually reviews this program and may make necessary revisions. Revisions are recorded in Appendix C.

The Approving Authority shall retain the responsibility for all policy revisions.

Application

This AWAIR program is intended to serve as an overview of all currently applicable Safety and Health programs. This program outlines the philosophy by which the **Grand Rapids Public Utilities** will develop, implement and maintain all other safety and health programs which concern more specific topics.

While compliance with the law and OSHA standards is an important objective, an effective AWAIR program must be tailored to the **Grand Rapids Public Utilities** particular needs. This program shall look beyond specific legal requirements to identify and analyze existing hazards. It shall seek to prevent injuries and illnesses, even when compliance is not an issue. Ultimately, the program's effectiveness in practice is what is important.

Should a department's operations require the need for a specific addition to this program, said specifics will be added as an addendum for that department and be maintained by that department within their operations.

Goals and Objectives

Central to our AWAIR program are the goals and objectives we've considered. The goals establish the direction for our program and state what we are attempting to achieve through this program. Our goals are generally challenging to reach or complete but are also possible to achieve. The goals are specific to **Grand Rapids Public Utilities**. Our objectives are specific actions that we will be taking to attempt to achieve those goals. Our objectives can either be measured or demonstrated.

The Goals and Objectives for our AWAIR program are identified in Appendix B.

Safety Committee

Grand Rapids Public Utilities has established a safety committee pursuant to Minnesota Statutes.

The safety committee will hold regularly scheduled meetings

All departments within the city's operations are encouraged to have Representatives on the Safety Committee. All representatives will serve on a voluntary basis. Terms of office will be revisited annually by individual departments. A chairperson and vice chairperson will be elected among the representatives.

Management/Supervisory personnel will have a representative on the safety committee.

The Utilities Commission may have a representative on the safety committee.

Safety Committee members will be able to perform their duties without fear discrimination or retaliation by management or the governing body.

Roles and Responsibilities

For Everyone in the Organization:

All employees, supervisors, and managers, must always follow all safety rules.

For Employees:

1. Employees must promptly report any safety and health hazards they observe to their supervisor or safety committee representative.
2. An employee's priority is to perform each job task safely. If an employee is unsure how to perform the task safely, he or she must consult with their supervisor.
3. Employees must wear personal protective equipment as required for their protection and maintain the equipment in a sanitary manner.
4. Employees must report all accidents and near misses to their supervisor immediately upon occurrence.

For Supervisors:

1. Supervisors must discuss any current safety issues with their employees at the beginning of all regularly scheduled staff safety meetings or at the tailgate/toolbox meetings.
2. Supervisors will address all safety concerns raised by staff by initially investigating the issue, determining if the concern is valid and taking appropriate corrective action whenever necessary. Corrective action can include ordering new equipment, issuing maintenance work orders or consulting with the safety director, the safety committee or upper management.
3. Immediately upon learning of an accident or near miss the supervisor must initiate an investigation and submit the completed accident investigation report to the safety director.
4. Supervisors will actively and positively participate in all safety committee inspections of their assigned areas.

For Safety Directors:

1. The safety director will serve as the lead person in the organization for safety and health issues and will serve as an ex officio member of the safety committee.
2. The safety director must review all First Reports of Injury and Accident Investigation Reports with the safety committee and take appropriate action to prevent recurrence.

3. The safety director or designee will conduct all safety training required by regulation or identified by management, supervision or the safety committee as a need to assure a safe workplace.
4. The safety director will recommend improvements in physical plant, machinery, equipment, raw materials and personal protective equipment to management, supervision, and the safety committee.

For Safety Committees:

1. The safety committee are encouraged to conduct monthly meetings and conduct area inspections to review accident reports, identify hazards and address safety concerns raised by employees, first-line supervision or the safety director.
2. The safety committee or authorized representative will review the AWAIR program at least annually and make recommendations concerning updates and revisions to the program to senior management and the safety director.
3. Safety committee members each represent their work area and, therefore, should address all safety concerns brought to them by their coworkers. These concerns should be handled by initially investigating the issue with the area supervisor to determine if the concern is valid and then, as necessary, and appropriate, bring the issue to the safety director or the full safety committee.

For Management/Administration:

1. Managers will communicate to all employees and supervisors the importance of worker safety and health throughout the organization.
2. Management shall review all safety concerns brought forward by the safety director, the safety committee or first-line supervision and take appropriate action.
3. Management shall review the AWAIR program and any recommended revisions from the safety committee at least annually, make the appropriate revisions and work with the safety director, the safety committee and first-line supervision to communicate the revisions throughout the organization.
4. Management also establishes the importance of the AWAIR program, both by the priority they give workplace safety and health issues and by the example they set by initiating safety and health improvements, correcting hazards, enforcing safety rules, rewarding excellent performance in safety and health, and by following all safety rules. Safety and health programs are similar to quality improvement and other efforts organizations engage in to continually improve performance, customer service, competitiveness, organizational culture, etc.

For Elected/Appointed Officials:

1. Officials will communicate to all Managerial/Administrative personnel the importance of safety and health throughout the city/utility.
2. Elected/Appointed Officials will provide the resources to improve safety and health throughout the entire organization. This includes providing employees and supervisors with the authority to identify and correct hazards, the budget to purchase new equipment or make repairs, the training necessary to work safely and to recognize hazards, and the systems to get repairs made, materials ordered and other improvements accomplished.

Enforcement of Safety and Health Programs

Enforcement of safe work practices should be fair, consistent throughout the city/utility, and based on established policy. Management and supervision should be conscious of the examples they set for the workplace and should obey the same rules as the rest of the workforce.

Unsafe or unhealthy work action by all employees shall be corrected in a timely manner based on the severity of the hazards. The enforcement of the program is based on the following methods:

1. Verbal warning
2. Written warning
3. Leave without pay
4. Termination

Or Take Safety Program Enforcement from union contract language agreement or current personnel manual.

Disciplinary action will follow the above sequence unless the situation warrants more severe action.

Not only should negative behavior be discouraged, but positive behavior should be reinforced as well. Exceptional performance or efforts in workplace safety and health should be recognized by the organization.

Hazard Identification, Analysis and Control

Grand Rapids Public Utilities may use the following to Identify, Analyze and Control hazards:

- Walk-around inspections by Supervisors, Management, or the Safety Committee
- Job or safety hazard analyses of different parts of the operation
- Inspections should be done on a regular basis to identify both newly developed hazards and those previously missed
- Periodic industrial hygiene monitoring and sampling for agents such as hazardous substances, noise and heat
- Job hazard identification checklists
- Employee reporting of workplace safety and health hazards
- Employee hazard abatement suggestions
- Preventative maintenance inspections
- Engineering controls
- Administrative controls
- Personal Protective Equipment
- Management and Employee Training

Grand Rapids Public Utilities may use the enclosed forms to assist in the identification, analysis, and control of hazards:

- SP 1 – Hazard Inventory
- SP 2 – Safety Inspection Checklist
- SP 3 – Report of Unsafe Conditions
- SP 4 – Hazard Elimination Evaluation Control Worksheet
- SP 5 – Job Hazard Analysis
- SP 6 – Indoor Environmental Audit
- SP 7 – Personal Exposure Monitoring
- SP 8 – Certification of Employee Training
- SP 10 – FROI Packet
- SP-11- Safety Action Report

Communication

All managers and supervisors are responsible for communicating with all workers about occupational safety and health in a form readily understandable by all workers. Our communication system encourages all workers to inform their managers and supervisors about workplace hazards without fear of reprisal. Our communication system may include one or more of the following items:

- New worker orientation including a discussion of safety and health policies and procedures
- Review of our program
- Training programs
- Regularly scheduled safety meetings
- Posted or distributed safety information
- A system for workers to anonymously inform management about workplace hazards

Contractor Duties

All contractors shall follow any Minnesota OSHA, Federal OSHA, MN DOT, MPCA and other regulatory agencies rules that pertain to their work sites in the State of Minnesota. All contractors shall be responsible for initiating, maintaining and supervising safety and health related policies, programs and work practices in connection with the performance of contractual work.

Duties to Subcontractors

Contractors that use sub-contractors shall be responsible for communicating any and all safety and health related information to those subcontractors and shall ensure that subcontractors initiate, maintain and supervise safety and health related polices, programs and work practices while performing subcontracted work.

Imminent Danger

If a Contractor's employee is exposed to an imminent danger situation, ***Grand Rapids Public Utilities'*** authorized representatives have the right to suspend the suspect operations/work task.

Imminent Danger Definition per MNOSHA:

Imminent danger situations are given top priority. An imminent danger is any condition or practice that presents a substantial probability that death or serious physical harm could occur immediately or before the danger can be eliminated through normal enforcement procedures. MNOSHA becomes aware of these situations through reports received from employees, the general public or direct observation by an investigator.

If an imminent danger situation is identified, the safety and health investigator will ask the employer to voluntarily eliminate the hazard and to remove the endangered employees from exposure. If the employer fails to do this, MN OSHA may "red tag" the equipment or job site for 72 hours.

Accident Investigation

Procedures for investigating workplace accidents, hazardous substance exposures, and near misses include:

1. Interviewing injured workers and witnesses.
2. Examining the workplace for factors associated with the accident/exposure.
3. Determining the cause of the accident/exposure.
4. Taking corrective action to prevent the accident/exposure from re-occurring;
and
5. Recording the findings and actions taken. It should not be to affix blame.

Each contributing factor should be traced back to its root cause. A written report that describes the accident, its causes and recommendations for corrective action and prevention will be prepared and presented to management.

The goal of the investigation is to determine the basic and root causes and to assign appropriate corrective action, so the incident does not happen again. To simply attribute an accident to "employee error," without further consideration of the basic causes, deprives the organization of the opportunity to take real preventive action. Possible use of engineering controls, improved work practices and administrative controls should be considered to help employees do their jobs safely. Management practices may also be considered as a possible basic factor. For example, if there is managerial or supervisory pressure to increase production or cut costs, employees may take unsafe shortcuts in work procedures or necessary preventive maintenance may be delayed or skipped.

The Accident/Injury Investigation Form (Form SP 10) may be used.

Figure 1: Accident and Injury Flowchart

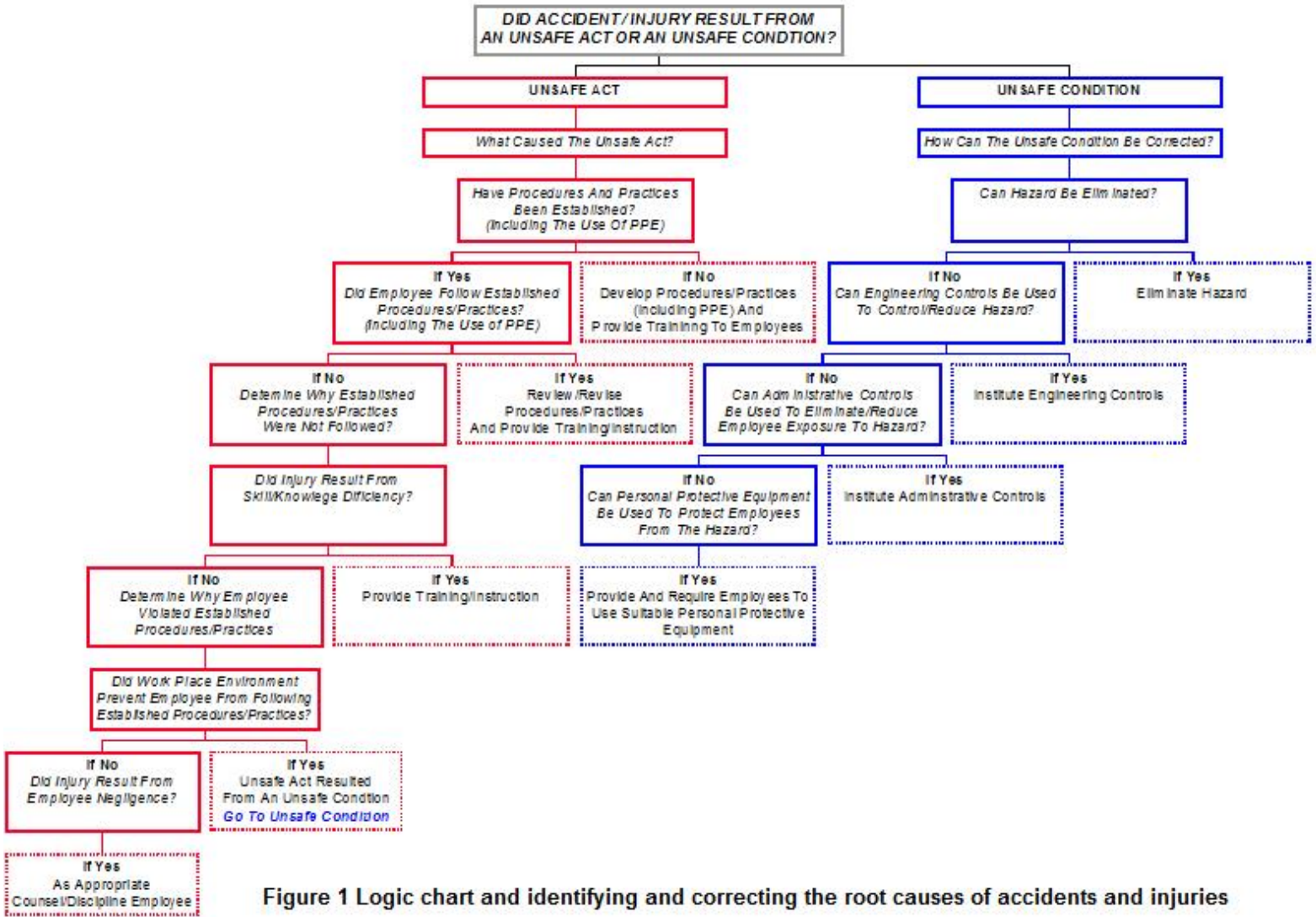


Figure 1 Logic chart and identifying and correcting the root causes of accidents and injuries

Program Evaluation

The Minnesota AWAIR Act requires employers to review the entire program at least annually and document the findings. Program review is vital, because it serves as a check to see if the organization is making progress towards its goal of creating a safer, healthier workplace for all employees. The annual review keeps the program fresh, accurate and an integral part of the organization.

The AWAIR Program Audit Form (Form SP-9) shall be used as a tool and record of the annual audit.

FORM SP-1 HAZARD INVENTORY

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

Check (√) those hazards that are present or that are likely to be present in the work place. Identify the source and location of each hazard that is present or likely to be present in the workplace. Evaluate and provide for the control all hazards identified in accordance with applicable regulations. Provide for employee information and training on all hazards identified in accordance with applicable regulations.

Facility: _____ **Area/Operation:** _____

Affected Positions: _____ **Compiled By:** _____ **Date:** _____

(√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <small>(identify hazard)</small>
ENVIRONMENTAL HAZARDS			
	Noise.	May cause stress, fatigue and/or loss of hearing. May interfere with communication and thereby contribute to accidents/injuries.	
	Air contaminants.	May cause illness, injury and/or death.	
	Hot environments.	May cause heat cramps, heat exhaustion and/or heat stroke. Serious cases may cause delayed injury or death.	
	Cold environments.	May cause frostbite and/or hypothermia.	
	Wet environments.	May cause illness or worker to slip, trip or fall. May result in injury or death.	
	Confined spaces.	May contain atmospheric, entrapment, engulfment and/or other serious hazards May result in injury or death.	
	Lighting.	May interfere with worker's ability to recognize job site safety and health hazards. May result in injury or death.	
	Biological.	Disease causing organisms or agents. May cause illness or death.	
	Microwave and other non-ionizing radiation	May cause thermal burns and heat build up in body tissues or other bodily injury. May result in injury or death.	

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

(√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
HAZARDOUS MATERIALS			
	Toxic substances.	May cause illness, injury or death.	
	Flammable substances.	May cause fire/explosion and/or illness, injury or death.	
	Reactive substances.	May react violently with other substances and/or cause illness, injury or death.	
	Corrosive substances.	May corrode metal, react violently with other substances and/or cause illness, injury or death.	
	Compressed gasses.	Cylinder may rupture and/or become a missile. Gas may be toxic, flammable, reactive, toxic and/or corrosive.	
	Infectious materials or disease causing agents.	Disease causing organisms or agents. May cause illness or death.	
	Radioactive materials.	May cause radiation burns and radiation sickness.	
	Asbestos containing materials.	Asbestos is known to cause asbestosis, lung cancer and mesothelioma.	
	Lead containing materials.	Lead is known to cause acute or chronic lead poisoning and/or injury to reproductive system. Know to cause birth defects.	
	Known carcinogens.	Cancer. May result in illness, death deformations or genetic changes.	
	Hot or molten materials.	May cause thermal burns. May produce harmful fumes.	
	Cryogenic liquids.	May cause frostbite. High expansion ratio (liquid to gas). Gas may be toxic, flammable, reactive, toxic and/or corrosive.	

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

(√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
PHYSICAL HAZARDS			
	Wet, slippery or cluttered floors, stairs or landings.	May cause worker to slip, trip or fall. May result in injury or death.	
	Floor openings or holes.	May cause worker to slip, trip or fall. May result in injury or death.	
	Unguarded platforms.	Worker may fall. May result in injury or death.	
	Rotating or moving machinery.	Worker may become caught between moving parts. May result in injury or death.	
	Hand and power tools.	Use may cause lacerations abrasions, fractures, amputations and/or electrocutions. May result in injury or death.	
	Abrasive grinders.	Use results in flying particles. Wheel may explode. May cause face/eye injuries.	
	Compressed air for cleaning.	Use may result in flying particles. May cause face/eye injuries.	
	Pressure vessels - air, steam, water or gas.	Mechanical explosion. May result in injury or death.	
	Fixed electrical equipment.	Electrocution and/or fire. May result in injury or death.	
	Portable electrical equipment and extension cords.	Electrocution and/or fire. May result in injury or death.	
	Head hazards (e.g. falling objects/bumps to head).	Worker could be struck. May result in injury or death.	
	Eye/face hazards (e.g. flying particles, harmful light and chemicals).	May cause blindness or injuries to face (e.g. cuts, thermal burns and chemical exposure/burns). May result in injury or death.	
	Hand hazards (e.g. sharp objects, heat/fire and chemicals).	May cause lacerations, abrasions, thermal burns and chemical burns/exposure. May result in injury or death.	

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

(√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
PHYSICAL HAZARDS, <i>continued</i>			
	Torso hazards (e.g. sharp objects heat/fire and chemicals).	May cause lacerations, abrasions, thermal burns and chemical burns/exposure. May result in injury or death.	
	Foot hazards (e.g. rolling or falling objects).	May cause lacerations and fractures. May also result in chemical exposure/burns.	
	Belt, chain and screw conveyors.	Worker may become caught between moving parts. May result in injury or death.	
	Hot surfaces/equipment.	Worker could receive thermal burns. Could ignite a fire. May result in injury or death.	
	Material storage.	May result in fire, falling object and/or slip, trip and fall hazards. May result in injury or death.	
	Hoists, cranes, slings and chains.	Equipment could fail. Employee could be struck by a falling object. May result in injury or death.	
	Limited exits and/or complex floor plan.	Workers may become trapped in a fire. May result in injury or death.	

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

(√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
ERGONOMIC HAZARDS			
	Workers routinely perform the same or pattern of motion within 30 seconds	May cause injuries to muscles, tendons and joints. May result in injury and/or disability.	
	Workers routinely maintain a fixed or awkward posture.	May cause injuries to muscles, tendons and joints. May result in injury and/or disability.	
	Workers routinely use vibrating tools or equipment.	May cause injuries to muscles, tendons and joints. May result in injury and/or disability.	
	Workers engage in unassisted frequent heavy lifting.	May cause injuries to muscles, tendons and joints. May result in injury and/or disability.	
	Workers routinely use forceful hand exertions.	May cause injuries to muscles, tendons and joints. May result in injury and/or disability.	
	Workers use tools which are not designed for the job.	May cause injuries to muscles, tendons and joints. May result in injury and/or disability.	
SHIFT WORK			
	Employees frequently work an extended or rotating shift schedule.	May cause stress and fatigue. May contribute to injuries and accidents.	
	Employees may be required to work double shifts.	May cause stress and fatigue. May contribute to injuries and accidents.	

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

(√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
WORK RELATED HAZARDS			
	Employees handle/use hazardous chemicals.	May cause illness, injury or death.	
	Employees remove or encapsulate asbestos.	Asbestos is known to cause asbestosis, lung cancer and mesothelioma. May result in illness and death.	
	Employees sand, grind, cut or weld on lead containing materials.	Lead is known to cause acute or chronic lead poisoning and/or injury to reproductive system. May result in illness and death.	
	Employees service or perform maintenance on equipment/machines.	Worker may become caught between moving parts. May result in injury or death.	
	Employees perform maintenance on electrical equipment.	Electrocutation. May result in injury or death.	
	Employees enter permit confined spaces.	May contain atmospheric, entrapment, engulfment and/or other serious hazards May result in injury or death.	
	Employees perform work from unguarded elevated surfaces.	Worker may fall. May result in injury or death.	
	Employees perform work in excavations and trenches.	Trench may cave-in. May result in injury or death.	
	Employees perform work on streets/roads	Worker may be struck by a vehicle. May result in injury or death.	
	Employees perform work in close proximity to heavy equipment.	Worker may be struck by a vehicle. May result in injury or death.	
	Employees operate heavy equipment (e.g. end loaders, trucks and ect.)	Vehicular accidents. May result in injury or death.	
	Employees operate forklifts.	Vehicular accidents. May result in injury or death.	
	Employees operate aerial lift trucks.	Boom could contact power line. Employee could fall. May result in injury or death.	

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

(√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
WORK RELATED HAZARDS, <i>continued</i>			
	Employees operate fixed/mobile cranes and hoists.	Worker could be struck by a falling object. Boom could contact a power line - worker electrocuted. May result in injury or death.	
	Employees perform welding, cutting and brazing.	Fire and explosion. Electrocution. Workers may be exposed to toxic metal fumes. May result in illness, injury or death.	
	Employees perform abrasive blasting.	Workers may be exposed to respirable silica dust and/or lead dust. May result in illness, injury or death.	
	Employees perform spray painting.	Workers may be exposed to toxic mists and sprays. Fire/explosion hazard. May result in illness, injury or death.	
	Employees come into close contact with soil or trash.	May result in tetanus if worker receives a cut, scrape or puncture wound.	
	Employees come into close contact with blood and other body fluids.	May be exposed to HIV or HBV. May result in illness and death.	
	Employees operate noisy tools and equipment.	May cause stress, fatigue and/or loss of hearing.	
	Employees work on or near high voltage electrical equipment.	Electrocution. May result in injury or death.	
	Employees perform work from ladders and/or scaffolds.	Worker may fall. May result in injury or death.	
	Employees control processes that involve hazardous chemicals.	Fire, explosion and/or exposure to a toxic or corrosive chemical. May result in illness, injury or death.	
	Employees operate fixed machines and equipment.	Equipment failures may result in fire/explosion, electrocution and/or flying material. May result in injury or death.	

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

<input type="checkbox"/> (√) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
EMPLOYEE EMERGENCY RESPONSE DUTIES			
	Designated employees have a duty to provide first aid/CPR.	May be exposed to HIV or HBV. May result in illness and death.	
	Designated employees have a duty to extinguish fires.	May result in thermal burns and/or the inhalation of hot/toxic smoke. May result in injury or death.	
	Designated employees have a duty to respond to hazardous chemical spills.	May be exposed to flammable, reactive, toxic or corrosive chemicals. May result in illness, injury or death.	
	Designated employees have a duty to perform rescues.	May be exposed to a atmospheric, entrapment, engulfment, fire, fall, electrical and/or moving equipment hazards. May result in injury or death.	
OTHER HAZARDS			

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

<input type="checkbox"/> (✓) If Present	Potential Hazard	Potential Harm	Source And Location Of Hazard <i>(identify hazard)</i>
OTHER HAZARDS			

FORM SP-2 SAFETY INSPECTION CHECKLIST

This checklist provides general guidance for the identification and correction of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place. Draw a line through those items that do not apply.

Check (✓) all unsatisfactory items/conditions and indicate location if applicable. Correct those unsatisfactory items/conditions that you are capable of correcting. Identify those items/conditions that need further action on reverse side. Note any new hazards. Review completed checklist with supervisor. Supervisors are to schedule corrective actions as required and submit completed checklist to safety committee.

Postings

- OSHA poster
- OSHA 300 & 300A (post 2/1 to 4/30 of each year)
- Hazards identified by signage
- Permit confined spaces signed
- Non-potable water identified by signage
- Floor load limits identified by signage
- No smoking areas identified by signage
- Emergency telephone numbers posted
- Escape routes/exits identified by signage
- Emergency equipment identified by signage
- NFPA 704 signs posted

Written Programs: Available To Employees

- Hazard Communication Program
- Respiratory Protection Program
- Hearing Conservation Program
- Hazardous Energy Control (Lo/To) Program
- Permit Confined Spaces Program
- Infection Control Program
- Fire Prevention/Emergency Action Plan
- Occupational Medicine Program

Tools/Equipment

- Condition of electrical cords
- Condition of hand/power tools
- Condition of abrasive grinders
- Air nozzles - pressure reduced to 30 psi
- Power tools - point of operation guarded

Electrical

- Breakers/panels identified
- Boxes/panels closed/covered
- Exposed conductors guarded
- Lights guarded/protected
- Condition of extension cords
- Circuits properly grounded

Fixed Machinery/Equipment

- Belts/pulleys guarded
- General maintenance
- Disconnects provided/identified
- Equipment properly grounded

Material Handling

- Condition of hoists/cranes
- Condition of slings/chains
- Condition of conveyors - trip line functional
- Condition of fork lifts

Material Storage

- Material neatly stacked and stable
- Shelves organized - no falling object hazard
- Accumulations of class A combustibles
- Aisle clear and free from obstructions
- General housekeeping

Hazardous Materials

- Proper containers
- Containers labeled
- MSDS's available
- Proper storage
- Flammables stored in approved cabinets
- Incompatibles separated
- Proper storage of compressed gas cylinders
- Flammable waste - containers emptied daily
- Damaged/deteriorated ACM

Working Surfaces/Housekeeping/Sanitation

- Aisle/floors/stairs kept clear/clean/dry
- General housekeeping
- Floor openings - covered/guarded
- Platforms/stairs guarded by railing
- Proper waste disposal
- Restrooms/locker rooms - clean/sanitary
- Eating areas - clean/sanitary

Ladders/Scaffolds

- Ladders - condition/proper use
- Fixed ladders - condition/fall protection
- Scaffolds - condition/proper use

Confined Spaces Entry Equipment

- Personal monitors - availability/calibration
- Retrieval equipment - availability/condition

Emergency Equipment

- First aid kit - in place/completely stocked
- Availability of persons trained in F.A./CPR
- Fire extinguishers - in place/charged
- Fire alarm operates when actuated
- Eye washes/showers - accessible/functional
- Emergency lights - proper operation
- Exits - accessible/not blocked
- SCBA's/PPE - availability/condition

PPE: Condition/Storage

- Respirators
- Hard hats
- Face/eye protectors
- Gloves
- Protective footwear
- Protective clothing
- Electrical protective equipment
- Personal fall protective equipment

Safe Work Practices: Employees

- Use proper lockout/tagout procedures
- Use proper confined space entry procedures
- Use suitable personal protective equipment
- Barricade hazardous work areas
- Guard temporary floor openings
- Use proper excavation/trenching procedures
- Use personal fall protective equipment
- Use GFI's

Vehicles/Mobile Equipment

- Tires/brakes/steering/lights
- General maintenance
- Proper operation of special equipment
- First aid kit - in place/completely stocked
- Fire Extinguishers - in place/charged

Employee Medical/Exposure Records

- Available for employee review

Describe Other Unsatisfactory Items/Conditions And/Or New Hazards

1. _____
2. _____
3. _____
4. _____
5. _____

Summary Of Unsatisfactory Items That Need Further Action

Item	Location

Area/Vehicle Inspected: _____

Conducted By: _____ **Date:** _____

FORM SP-3 REPORT OF AN UNSAFE CONDITION

Instructions to employees: Briefly describe the location and nature of the unsafe condition. Identify any possible corrective actions. Sign/date the report. Submit report to your immediate supervisor.

To be completed by Employee reporting the unsafe condition

Location: _____

Describe unsafe condition: _____

Suggested corrective actions: _____

Reported by: _____ Date: _____

To be completed by Supervisor

Received by: _____ Date: _____

Suggested corrective actions taken

Referred to safety committee

Comments/actions taken: _____

To be completed by Safety Committee

Date reviewed/acted upon: _____

Recommendation of safety committee: _____

Corrective actions initiated by safety committee

Corrective actions referred to work unit manager for review/initiation

To be completed by Management

Date Acted Upon: _____

Actions taken: _____

FORM SP-4 HAZARD EVALUATION AND ELIMINATION/CONTROL WORKSHEET

This checklist provides general guidance for the evaluation and elimination/control of workplace safety and health hazards. It is not all inclusive. The employer must customize the form for the specific work place.

Use this worksheet to identify how hazards identified in the workplace hazard survey will be eliminated or controlled. (The worksheet may also be used to analyze specific operations or areas). For each hazard; identify the source and location of each hazard in *column 1*, identify the cause and severity of the hazard in *column 2* and the means/methods of hazard eliminate/control in *column 3*.

Facility: _____ Area/Operation: _____

Affected Positions: _____ Compiled By: _____ Date: _____

Hazard Source/Location	Hazard Evaluation <i>Identify cause and severity of hazard. Include results of personal monitoring if applicable.</i>	Methods/Mean Of Hazard Elimination/Control <i>Identify means and methods that will be used to eliminate or control the hazard. Consider hazard elimination, engineering controls, administrative controls, procedures and work practices, employee training and personal protective equipment.</i>

FORM SP-5 JOB HAZARD ANALYSIS

Instructions: Refer to OSHA publication 3071, Job Hazard Analysis for additional information and instructions.

Task: _____ Conducted By: _____ Date: _____

Job Step	Hazard	Cause	Preventive Measure

Page: _____ of: _____

FORM SP-6 INDOOR ENVIRONMENTAL AUDIT

This checklist provides general guidance for the identification of common work place hazards. It is not all inclusive. The employer must customize the form for the specific work place.

Name of Facility:				Conducted By:			Date:		
Location	Airborne Contaminants					Lighting	Noise	Temperature Humidity	
	Oxygen (percent)	Carbon Monoxide (ppm)	% of LEL		Ventilation	Light Level (foot-candles)	Noise Level (dB-A)	Temperature (F°)	Relative Humidity (percent)
Comments:									

FORM SP-7 RESULTS OF PERSONAL EXPOSURE MONITORING

Facility:					Department or Area:			
Operation:					Employee:			
Employee SS Number:			Date:		Temperature:		Relative Humidity:	
Type of Respirator Used By Employee:					Comments/Observations:			
Sample Type:					Sampling Device and ID. No:			
Calibration (date and results):					Settings/Range:			
Collection Media:					Analysis Method:			
Sample Number	Start Time	Stop Time	Duration (minutes)	Calibration Flow Rate	Volume (liters)	Substance Sampled	Amount Collected	Concentration In Air
Substance Sampled			Actual Employee Exposure			Permissible Exposure Limit (PEL)		
Recommendations:						Sampling Conducted By:		



Minnesota Municipal Utilities Association

FORM SP-8 CERTIFICATION OF EMPLOYEE TRAINING

Title of Training Session:				
Topics Discussed (Check Those That Apply)				
AV Material: (If Used)				
Method Used To Evaluate Effectiveness of Training: (Check Method Used)			Post Training Test	Workplace Inspections
Name of Facilitator:			Date:	
Location:		Start Time:		End Time:



Minnesota Municipal Utilities Association

FORM SP-9 SAFETY AND HEALTH PROGRAM AUDIT WORKSHEET

This worksheet provides general guidance for evaluating safety and health program effectiveness. It is not all inclusive. The employer must customize the form for the specific work place.

Consider each program element to; (1) determine whether or not the element is in place, (2) estimate the element's overall effectiveness and (3) identify specific deficiencies and actions that can be taken to improve the effectiveness of the element.

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
1. Employer Commitment Employer has adopted and endorsed an effective and proactive written safety and health program that encourages employee participation.								
Employer has adopted a safety and health related vision (or policy) statement. Vision (or policy) statement has been communicated to managers, supervisors and employees.								
Employer has adopted safety and health related policies, procedures and practices. Safety related policies, procedures and practices have been communicated to managers, supervisors and employees.								
Employer has committed those human and material resources necessary to implement and manage the safety and health program.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Employer has (established and communicated) safety and health related responsibilities for managers, supervisors and employees.								
Employer has provide means and methods for managers, supervisors and employees to meet assigned safety and health related responsibilities.								
Employer has assigned accountability by adopting and enforcing a safety program compliance policy. Managers, supervisors and employees are required to comply with safety related, policies, procedures and practices and are held accountable for their actions.								
Employer includes work place safety and health as an agenda item in staff meetings.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Employer requires managers and supervisors to take a visible and active role in safety meetings and training sessions.								
2. Employee Involvement Employer provides for employee input and involvement in safety and health program. Employees (or their designated representative) have endorsed the safety and health program.								
Employer provides for employee involvement (and solicits employee input) in all matters pertaining to work place safety and health, including but, not limited to; work place hazard assessments and inspections, hazard mitigation and training.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Employer has provided employees with an effective means to report unsafe working conditions. Employees are not subjected to retaliation or harassment for reporting unsafe acts or conditions.								
Employer schedules safety meetings and training sessions during normal working hours and/or with employees in pay status.								
Employer has established an effective and proactive safety committee. Safety committee has defined goals and objectives. Safety committee meets on a scheduled basis. Safety committee activities are communicated to managers, supervisors and employees.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
3. Hazard Control A Systematic survey has been conducted to identify all work place safety and health hazards. Results have been communicated to managers, supervisors and employees.								
Hazards posed by new processes, machines and chemical products are identified. Results are communicated to managers, supervisors and employees.								
Frequent walk-through safety inspections are conducted to identify unsafe acts and unsafe conditions. Results are communicated to managers, supervisors and employees.								
As a matter of routine first-line supervisors and employees report and/or correct unsafe acts and conditions.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Appropriate methods are used to evaluate hazards to determine cause, severity and effective methods of elimination/control. Results are communicated to managers, supervisors and employees.								
Appropriate and suitable methods are used to eliminate or control safety and health hazards. When practical and feasible hazards are either eliminated, or controlled by engineering and/or administrative controls. Employer solicits employee input when considering hazard mitigation options.								
Work place safety and health hazards are promptly corrected by managers, supervisors and employees.								
Written safety and health programs have been implemented (and communicated to managers, supervisors and employees) as required by work place hazards, employee job duties and applicable OSHA regulations. Each program is effective in meeting it's intended purpose as is periodically reviewed.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Written procedures and work practices (SOP's) have been implemented (and communicated to managers, supervisors and employees) as required by work place hazards, employee job duties and applicable OSHA regulations. Each SOP is effective in meeting the intended purpose as is periodically reviewed.								
4. Facility Maintenance Structures, vehicles and equipment are properly maintained in accordance with applicable regulations, codes and manufacture's instructions through an effective work order systems that facilitates planned maintenance and the reporting of items in need of repair.								
Effective housekeeping procedures and assignments have been established (and communicated to managers, supervisors and employees). Facility is maintained in a clean and sanitary condition.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
5. Accident Analysis Managers, supervisors and employees are required to report all accidents and injuries including close calls.								
All accidents, injuries and close calls are investigated to determine root cause and appropriate corrective measures. Results are acted upon and communicated to managers, employees and supervisors.								
Accident and injury records are reviewed and analyzed to identify recurrent hazards. Results are acted upon and communicated to managers, employees and supervisors.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
6. Occupational Medicine An affective and proactive occupational medicine program has been established as required by work place hazards and applicable regulations. All affected personal participate in the program. Results and recommendations are appropriately communicated and								
7. Contractor Safety Employer has established (and abides by) a policy of retaining only qualified contractors with a demonstrable record of employee safety and health and regulatory compliance.								
Safety and health related duties and responsibilities for contractors (and subcontractors) are clearly stated in bid and/or contract documents.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Contractors are informed of work place hazards, safety related policies, procedures and practices in accordance with applicable regulations. Contractors are required to observe (or exceed) the host employers safety and health related policies, procedures and practices.								
8. Employee Training Employees are informed of their rights and responsibilities under the OSHA act by posting of the OSHA poster and are informed of work place injuries and illnesses by posting of the OSHA 200 Log between February 1 and March 1 of each year.								
Employees are provided with access to safety and health related information including; applicable regulations, policies, procedures, material safety data sheets and to their training, medical and exposures records. Location of said information is communicated to employees.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Employees are informed of work place safety and health hazards by appropriate signs, labels and tags.								
New employees are provided with effective training that includes information on work place hazards, safety related policies, procedures and practices, and instruction on specific job duties. First line supervisors and experienced employees take an active role in the training of new employees. The training is documented.								
In-service topical and refresher training and instruction is provided on routine and scheduled basis as required by applicable regulations, new hazards, procedural changes and deficient work practices. The training is documented.								
Work unit supervisors conduct frequent job briefings, tool box safety talks and/or tailgate safety talks to communicate safety and health related information and/or work specific hazards and hazard control procedures.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Employees actively participate in safety training and communicate training needs to management.								
Appropriate means and methods are used to evaluate the effectiveness of training.								
9. Emergency Response Effective and proactive policies, procedures and practices have been established (and communicated to managers, supervisors and employees) to prevent fires and other work place emergencies. Procedures are established in a fire prevention plan.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	
Emergency equipment (exits and exit ways, fire extinguishers, first aid kits, emergency eye wash stations and showers and emergency lights) is installed, inspected and maintained in accordance with applicable regulations. Emergency telephone numbers are consciously posted.								
Duties and procedures to be followed in all reasonably foreseeable emergencies have been identified in an emergency action plan. Plan has been communicated to managers, supervisors and employees.								
Managers, supervisors and employees are provided with emergency response training as required by assigned duties and applicable regulations. Personnel trained in CPR/first aid a readily available at work place.								
Local fire department has been informed of work place hazards in accordance with applicable regulations, has toured the facility and has developed emergency plan.								

Program Element	In Place (√)		Effectiveness (√)					Identify Specific Deficiencies And Actions That Can Be Taken To Improve Program Effectiveness
	Yes	No	1 <i>(poor)</i>	2	3 <i>(fair)</i>	4	5 <i>(Excellent)</i>	

Audit Conducted By: _____ **Date:** _____



GRAND RAPIDS
IT'S IN MINNESOTA'S NATURE

PUBLIC UTILITIES COMMISSION

500 SE 4TH STREET PO BOX 658
GRAND RAPIDS, MINNESOTA 55744
TELEPHONE (218) 326-7024
TDD (218) 326-7487 FAX (218) 326-7499

Memorandum

To: GRPUC Department Managers
CC: HR Assistant Flannigan, HR Assistant
From: Julie Kennedy, General Manager
Date: May 16, 2017
Re: First Report of Injury (FROI) Submittal Process

Please communicate to all employees within your department the following process for submitting First Report of Injury (FROI) paperwork for an employee experiencing a work-related accident. **These steps should be completed within 24 hours of the accident.**

1. The Employee immediately notifies their Supervisor of the work-related accident. If their Supervisor is unavailable, notify General Manager.
2. Together, the Employee completes the *Employee Incident Report Form* (either fillable or hard copy) and the Supervisor (or General Manager if Supervisor is unavailable) completes the *Supervisor's Report of Accident Form* (either fillable or hard copy). Forms can be found in the following folder: P:\Managers\Managers Forms\Accident Reporting.

DO NOT SAVE FORMS – COMPLETE, PRINT, SIGN AND THEN CLOSE DOCUMENT WITHOUT SAVING.

3. The Supervisor prints both forms and the Employee and Supervisor each sign and date their Form. The Supervisor scans both signed Forms to the HR Assistant (or General Manager if HR Assistant is unavailable) and place hard copies in HR Assistant's mailbox.
4. The HR Assistant (or General Manager if HR Assistant is unavailable) completes the *FROI Form* and submits it to the LMCIT Workers' Compensation Claims Department. General Manager is copied on submittal.
5. The HR Assistant (or General Manager if HR Assistant is unavailable) provides a copy of the submitted *FROI Form* and *Minnesota Workers' Compensation System Employee Information Sheet* to the Employee.
6. The HR Assistant (or General Manager if HR Assistant is unavailable) emails the Safety Manager and Union President the completed *FROI Form* with confidential information redacted.
7. The HR Assistant (or General Manager if HR Assistant is unavailable) notifies the Employee and the Safety Manager of future correspondence from the LMCIT Workers' Compensation Claims Department.

Forms:

- A. *Employee Incident Report*
- B. *Supervisor's Report of Accident*
- C. *First Report of Injury (FROI)*
- D. *Minnesota Workers' Compensation System Employee Information Sheet*

EMPLOYEE INCIDENT REPORT

Note: Please complete this form and return it to your supervisor immediately. Please complete each question and if you need medical attention, call: _____

Employee Name (last, first, middle): _____

Employee Home Address: _____

City, State & Zip Code _____

Date of Birth: _____

Phone Number: _____

How long employed? _____

Department: _____

Job Title: _____

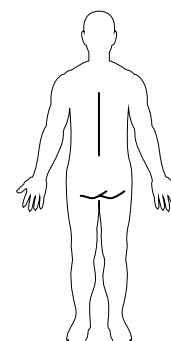
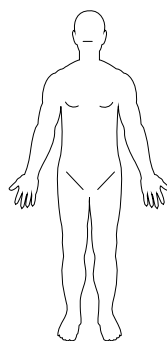
Supervisor: _____ Who did you notify of this incident? _____

Date of Incident: _____ Time of Day: _____ am/pm Day Occurred: S M T W TH F S

Location of Incident: _____

Describe exactly what happened & how the incident occurred. Include details pertaining to equipment, environment, work location, work tasks, etc.: _____

_____ **Indicate on the Diagram the location of your injury(ies):**



Was first aid administered? Yes No When? _____

By whom? _____

Did you go to the Hospital? Yes No When? _____

Where? _____

Did you go to the Clinic? Yes No When? _____

Where? _____

Did you see a physician, chiropractor, nurse practitioner or seek other medical attention? Yes No

When? _____ Who? _____ Where? _____

Do you intend to seek additional medical care for this injury? Yes No

Who witnessed the incident? _____

How much time did you miss because of this incident? _____ When? _____

What actions do you intend to take to avoid this in the future? _____

Do you have other regular employment? Yes No Where? _____

Employee's Signature: _____ Date: _____

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION3, MNWC STATE STATUTE 60A.955.

SUPERVISOR'S REPORT OF ACCIDENT

This form should be completed by the supervisor as soon after a work accident as possible. It is useful in gathering information for investigating accidents and their causes so that corrective action can be taken and future accidents avoided. Every accident should be investigated and the causes corrected.

Name of Employee: _____ City/City Organization: _____ Dept.: _____

Date of Accident: _____ Time of Accident: _____ Did employee lose time from work? YES NO

Hours lost on day of accident: _____ Has employee returned to work? YES NO

Employee's job title: _____ Years of employee's service with City/City organization: _____

Years employee has been in present job: _____ Number of hours employee works per week: _____

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING:

CHECK "YES" OR "NO"

- | | | | |
|-----|--|------------------------------|-----------------------------|
| 1. | HAD INJURED PERSON BEEN PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. | DID INJURED PERSON VIOLATE ANY INSTRUCTIONS? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. | WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE) | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. | DID POOR HOUSKEEPING CONTRIBUTE TO INJURY? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5. | DID HORSEPLAY CAUSE THE INJURY? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. | WAS INJURY CAUSED BY SOMETHING THAT NEEDED REPAIRS? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7. | SHOULD A GUARD BE PROVIDED? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8. | DID ANY BODILY DEFECT CONTRIBUTE TO INJURY? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 9. | WAS INJURY CAUSED BY AN UNSAFE ACT? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 10. | DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

ACCIDENT. (Describe what the injured employee was doing at the time of the accident, what happened, who was involved, nature of the injury.) _____

Witnesses' Names _____

UNSAFE ACTS. (Did the injured employee or another person do something incorrectly?) _____

UNSAFE CONDITIONS. (What unguarded or unsafe condition of machinery, equipment, building or premises was involved?) _____

ACTIONS TAKEN. (After the injury, what did the employer do to correct the conditions that caused the injury?) _____

REMEDIES. (What should the employer do to prevent other injuries like this?) _____

MEDICAL CARE. Did the employee go to the Doctor or Hospital? YES NO If yes, please complete the following:

Name of Doctor or Hospital: _____ Date of initial visit: _____

Address: _____ Telephone number: _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES NO

Reasons why or why not: _____

Report Submitted By: _____ Date: _____

First Report of Injury

See Instructions on Reverse Side



Print in ink or type
 Enter dates in MM/DD/YYYY format

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA case #		3. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm	
4. DATE OF CLAIMED INJURY		5. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm		6. Date of death # of dependents (if death is related to injury)	
7. EMPLOYEE Name (last, suffix, first, middle)				8. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
				9. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried	
10. Home address			11. Home phone #		12. Date of birth
City State Zip Code			14. Occupation		13. Date hired
			15. Regular department		16. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Average weekly wage		18. Rate per hour	19. Hours per day	20. Days per week Normal work schedule Sun - Sat <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S	
				21. Employment status (check all that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer	
22. Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was. Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."					
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.			24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.		
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Name and address of the place of the occurrence		26. Date of first day of any lost time		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI	
		28. Date employer notified of injury		29. Date employer notified of lost time	
		30. Return to work date		31. RTW same employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
				32. RTW with restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No	
33. Treating physician (name)		34. Extent of medical treatment (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Minor on-site by employer's medical staff <input type="checkbox"/> Minor clinic/hospital <input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization more than 24 hours <input type="checkbox"/> Future major medical anticipated			
35. Certified Managed Care Organization (if any)					
36. EMPLOYER Legal name			37. EMPLOYER DBA name (if different)		
38. Mailing address			39. Employer FEIN		40. Unemployment ID #
City State Zip Code			41. Employer's contact name and phone #		
42. Physical address (if different)			43. Witness (name and phone) - if more than 1 attach a separate sheet		
City State Zip Code			44. NAICS code		45. Date form completed
46. INSURER name			51. CLAIMS ADMIN COMPANY (CA) name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA		
47. Insured legal name and FEIN			52. CA address		
48. Policy # (including effective dates) or self-insured certificate #			City State Zip Code		
49. Insurer FEIN		50. Date insurer received notice		53. CA FEIN	
				54. CA claim #	
55. To be completed by the CA:		Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?
					Death result of injury?

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see <https://www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Lost-or-Misplaced-Your-EIN>.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR (For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Minnesota Workers' Compensation System

Employee Information Sheet

What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start)
- Benefits for permanent damage or loss of function of a body part
- Benefits to your spouse and/or dependents if you die of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer

How are workers' compensation benefits paid?

Your workers' compensation benefits are paid by an insurance company or your employer, if your employer is self-insured. State law sets the benefit levels. Please note: pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

If the insurer accepts your claim for wage loss benefits and you have been disabled for more than three calendar days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer denies your claim for wage loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

Insurer name: [League of Minnesota Cities Insurance Trust](#) **Phone:** 651-281-1200 or 1800-925-1122

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to see what to do next.

If you have other questions or need more help, call:

Minnesota Department of Labor and Industry Worker's Compensation Hotline:

Twin Cities and Southern Minnesota: (651) 284-5005 or 1-800-342-5354; TTY (651) 297-4198
Duluth and Northern Minnesota: (218) 733-7810 or 1-800-342-5354

Your call will be answered by experienced workers' compensation specialists, who will provide **instant, accurate information and assistance.**

Additional workers' compensation information is available on the department's Web site at:

www.dli.mn.gov/WorkComp.asp

Your employer is required by law to give you this information. This material can be made available in different formats, such as large print, Braille or audio, by calling the numbers printed above.

PUBLIC UTILITIES COMMISSION
SAFETY ACTION REPORT

Name of Employee _____ Department _____

Name of Supervisor _____

Job Title _____ Date & Time of Injury _____

Witnesses _____

First Aid Case Medical Case No Injury Property Damage

Describe the extent of injury listing part of body injured/property damage:

Describe in detail how the accident occurred: _____

Was the point of accident guarded? Yes No

Was a safety rule violated? Yes No If so, which rule? _____

Was the employee informed, acquainted, and properly trained in the operation taking place when the accident occurred? Yes No If so, why not? _____

What was the primary unsafe act or unsafe condition, which was the most significant factor in causing the accident? _____

What time did Safety Action Team report to scene of accident? _____

Chief Investigator's signature _____ Date _____

Attention Investigator: Deliver immediately to the Safety Action Team Chairman. What action, if any, has been taken in the above accident? _____

Safety Action Team Chairman _____ Date _____

Copies to: General Manager, Employee's Dept Manager, Secretary Safety Committee