FORMS SCHEDULE

Form	Frequency
New Employee Orientation Checklist	Orientation, first day of employment
Follow-Up Orientation - same form as the orientation	6-8 weeks after hire
Emergency Contact Form	At orientation, updated annually
Drug and Alcohol Testing Acknowledgement	Orientation, first day of employment
Personal Protective Equipment Training	At orientation
Job Inventory	Ongoing
Tasks List	Ongoing
Job Hazard Analysis / Procedure	Ongoing
General Safety Meeting Minutes	Monthly
On The Job Training Record	As Completed
Training Records	Ongoing
On-Going Job Observations	Ongoing
Short Service Employee Form	As needed
Modified Work - Physicians Letter	After an injury to a worker
Modified Work - Fitness for Work Form	After an injury to a worker
Modified Work - Modified Work Offer	After Fitness for Work Form is completed
Personal Protective Equipment Inspections	Monthly
Inventory of Assets (>$250)	Ongoing
Maintenance Schedule	Update with any new tool or equipment
Vehicle/Equipment Maintenance Records	Ongoing
Pre-Trip Vehicle Inspection Report – Non NSC Vehicles	Pre-Trip
Journey Management Form	Prior to a Hazardous Journey
Pre-Job Site Hazard Assessment and Control Measures	Pre-job
Office Inspection Checklist	Monthly
Shop Safety Inspection Form	Monthly or Weekly
Worksite Inspection Checklist Form	At all projects
Daily Tail Gate Safety Meeting	Daily
Record of Drill	Annually – as a minimum
H_2S / 4 Head Monitor Bump Test Tracking Form	Ongoing
Personal Monitor Readings	As Required
Hazard Report Form	As a hazard is noticed
Working Alone Schedule	Prior to working Alone
Policy/Regulation Violation	After a violation
Employee Warning Report	After a Warning
Work Refusal Investigation	Immediately after a worker refuses to work
Near Miss Report Form	Immediately following a Near Miss
Accident/Incident Investigation Report Form	Immediately following a Accident/Incident
First Aid Record	After First Aid incident
Statistics	Monthly
Safety Activity Summary	Monthly, Quarterly or Annually
Safe Job Procedures Inventory	Ongoing and Reviewed Annually
Year End Injury Summary	Monthly

New Employee Orientation Checklist

Check Once Discussed	
	Administrative
	Hours of work, breaks…Expectations
	Benefits (health care, dental, life insurance)
	Pay Period/Time sheets
	Systems (Filing, Storage, etc.)
	Work Expectations/Job Description/Titles/Probationary Period
	Company Policies, Ethics and Principles
	Key's/Code/Fire Alarm & Help
	General Tour of Work Area including Location of Washrooms
	Introduction to Key Personnel
	Work Stations (how to use computer, fax and copier)
	Professional appearance and behaviour expected
	Safety
	Review Safety Policy
	Safety Meetings (types and frequency) Go over the last General Safety Meeting Minutes
	Legislation Affecting Your Work
	Accident and Near Misses, Reporting Procedure
	Right To Refuse Dangerous Work
	Job Hazards (Hazard Assessments)
	Safety Precautions
	Personal Protective Equipment (PPE) – Use, Care and Maintenance
	Job Procedures
	Job Training Requirements (WHMIS, H_2S, First Aid, Ground Disturbance, PST Training)
	Location of Fire Extinguisher, First Aid Kits and Equipment
	Emergency Procedures
	Form's (how to fill them in and who to submit them to)
	Security awareness, theft, and workplace violence
	Fire Fighting- Incipient training
	Lifting Techniques
	Field Job Preparations
	Driving and vehicle policies/ Insurance Requirements
	Alarms, Excavations, Muster Areas (This is site specific)
	Safe work permits (maybe required)

I understand and accept my responsibilities as outlined in the New Employee Orientation.

_____	_____
Worker Signature/ Position	Supervisor's Signature/ Position
_____	_____
Date of Orientation	Date New Employee Started Work
_____	_____
Date of Follow-Up Orientation	Follow-Up Orientation Performed by

Emergency Contact Form

EMERGENCY CONTACT INFO
Name:
Address:
Mailing Address (if different from above):
Home Telephone:
Home Fax:
Cell Phone:
Email Address:

NEXT OF KIN
Name:
Relationship:
Address:
Telephone:
Alternate Phone:

ALTERNATE CONTACT
Name:
Relationship:
Address:
Telephone:
Alternate Phone:

Medical Conditions (list any prescription medications or health issues that may affect your ability to work or be of a concern in a medical emergency):
N/A

Drug and Alcohol Testing Acknowledgment

I _____ (worker) have reviewed the company Drug and Alcohol Policy. I am aware of the zero tolerance policy and the fact that I may be subject to testing (random, pre-access, testing for cause, re-qualification testing, post incident, and return to work).

Employee _____

Supervisor _____

Date _____

This constitutes the 30 day notice for all employees.

Personal Protective Equipment – Training

Person Being Trained: _____
Signature _____

Trainer: _____
Date: _____

Place a check next to the items worker will be required to wear.

☐ **Hard Hat**
- CSA Approved
- Check for cracks and wear
- Do not put stickers (except those provided by our clients) on it
- Use Snell approved helmet on ATV and snow machine…always

☐ **Coveralls**
- Must be fire resistant
- All clothes worn under must be made of natural fibres
- Good condition (no rips or tears)
- Reflective stripes

☐ **Safety Glasses**
- CSA Approved
- Check for scratches
- Contact Lenses - Please refrain from wearing contact lenses at any dusty sites

☐ **Boots**
- CSA Approved
- Steel toe and shank and chemical resistant

☐ **Hearing Protection**
- CSA Approved
- 3 spare sets of plugs or 1 pair of earmuffs in vehicle

☐ **Hand Protection**
- Leather work gloves
- Chemical gloves (if required)

☐ **Warm Weather Clothing**
- Extra warm clothes all seasons

☐ **Chemical Barriers**
- Bug Spray
- Sunscreen

☐ **Animal Protection**
- Bear Spray – do not leave in vehicle
- Bear Bells

☐ **First Aid Kit**
- Has it been used?
- Clean, dry, and serviceable

☐ **Fall Protection**
- Check for wear
- Proper for the task

☐ **Respiratory Protection**
- Fit testing
- Proper for the task

If the use of the PPE may itself cause a hazard…STOP.

- On very hot days assess whether the risk of wearing coveralls is greater than the risk of heat exposure. Talk this over with a local operator if you want to NOT wear coveralls.
- Do not wear scratched lenses, ripped coveralls, etc STOP work and replace immediately.

Job Inventory

Position	Position's Responsible For

Tasks List (this must be filled in for each job listed in the Job Inventory)

Job Position:_____

Task	Critical	JHA completed

Job Hazard Analysis / Procedure

People performing JHA: _____ Date Completed: _____

_____

_____

Job being Analysed:				
Sequence of Steps		**Potential Accidents or Hazards**	**Hazard Rank**	**Controls**
Personal Protective Equipment required:				
1				
2				
3				
4				
5				
6				
7				
8				

Hazard Priority Ranking

The first ranking estimates the severity of the problem if the potential accident/incident were to occur:

1. Imminent Danger (e.g. causing death, widespread occupational illness, loss of facilities)
2. Serious (e.g. severe injury, serious illness, property and equipment damage)
3. Minor (e.g. non-serious injury, illness, or damage)
4. Negligible/Ok (e.g. minor injury, requiring first aid or less)

The second ranking estimates the probability (think in terms of risk assessment) of the accident/incident occurring:

A. Probable – Likely to occur immediately or soon
B. Reasonably probable – likely to occur eventually
C. Remote – could occur at some point
D. Extremely remote – unlikely to occur

General Safety Meeting Minutes

Date of Meeting _____

Attendees

Topics Discussed

1. Last meetings key decisions, Action Plans, and follow-up.
2. Recent incidents/accidents that have occurred at Wellsite Geologists and in the industry.
3. New policies.
4. Discussion and resolution of safety issues.
5.
6.
7.
8.
9.
10.
11.
12.

Action Plan

Action Item	Person Assigned	Due Date

On The Job Training Record

Employee:_____ Position:_____

Critical Task	Date of Training	Trainer	Comments (observations, competency, method of training)

Training Records

										Shade the required training associated with each person, enter the Expiry Dates of the training. A photocopy of all training is required. The training records must be kept on file.
PPE Training										
PST/CST Training										
Driver's Education										
ATV Safety										
Ground Disturbance										
H_2S										
WHMIS										
First Aid and CPR										
Workers Name										

On-Going Job Observations

Date _____
Worker(s) _____
Observer _____
Task Being Observed _____

Observations and Comments _____

Actions Discussed/Required _____

Date _____
Worker(s) _____
Observer _____
Task Being Observed _____

Observations and Comments _____

Actions Discussed/Required _____

Short Service Employee Form

SSE Employee Information

SSE Name:			
Date of Employment:	Current Job Title:		
Years Related Experience:	Experience in Current Position:	Yrs	Months
Is this employee in compliance with the Substance Abuse Policy?		Yes	No
Have site owner, contractor and HES policies been reviewed with SSE?		Yes	No
Who has been assigned as the SSE's mentor?			
Mentor's Experience: Yrs Months			
List all training provided to the SSE:	List any previous special training:		
SSE(s) identified by:	Hi Vis. Orange Hard Hat	SSE Letters on Hard Hat	

SSE Crew Composition

Choose one of the crew types below. If any of the limitations are exceeded, obtain written authorization from the supervisor.

☐ Single person crew – cannot be an SSE (Variance Required)

☐ 2 – 4 person crew – no more than one SSE

☐ 5 or more person crew – no more than 20% SSE(s) per crew

☐ Exceeding 20% SSE per crew (Variance Required)

SSE Review and Approval

Supervisor:	Date:

Variance Information

Variance Justification (What are the current circumstances and what will be done to ensure an acceptable level of risk?)	
Alternatives to Variance (If the variance is denied, what are the alternatives to completing the scope of the work? Briefly detail the cost and operational impact of the alternatives.)	

List the steps to be taken to manage/mitigate the SSE risk to an acceptable level:

1.
2.
3.
4.
5.
6.
7.
8.
9.

Variance Review and Approval

Supervisor:	Date:

Dear Attending Physician:

Please be advised that Wellsite Geologists maintains an effective modified work program in compliance with the requirements of the Workers' Compensation Act.

We would ask that you return our employee to modified work if he or she is capable.

We are able to accommodate workers restricted to sedentary and semi-sedentary work tasks and will make any arrangements for ongoing treatment and rehabilitation as part of our commitment to our injured worker.

Please note that we will pay the fee for the completion of the attached Fitness for Work Form. The worker will be reimbursed once the completed form has been submitted to us.

Please feel free to contact us should you require additional information regarding our injured employee or our Modified Work Program in general.

Yours truly,

Wellsite Geologists

Modified Work - Fitness for Work Form

DATE:	PROJECT:	PROJECT LOCATION:	PROJECT NUMBER:

CONTACT NAME:	CONTACT PHONE:	CONTACT FAX:

SECTION A (COMPLETED AT SITE BY DESIGNATED FIRST AID PROVIDER)

NAME:	DATE OF ACCIDENT:	DATE OF BIRTH:
HEALTH CARE NO:	SIN/CLAIM NO:	
DESCRIPTION OF INJURY:		
TREATMENT GIVEN:		

I authorize the release of any relevant medical information/records related to my current medical conditions to my employer representative.	
SIGNATURE:	DATE:

SECTION B (COMPLETED BY TREATING PHYSICIAN)

WALKING/STANDING:	❑ Only Short Distances ❑ No kneeling/squatting ❑ Other: No more than: ❑ 2 hrs ❑ 4 hrs ❑ 6 hrs ❑ 8 hrs ❑ 10hrs ❑ Other:
LIFTING/CARRYING:	No more than: ❑ 2 hrs ❑ 4 hrs ❑ 6 hrs ❑ 8 hrs ❑ 10hrs ❑ Other: No more than: ❑ 10lbs ❑ 20lbs ❑ 30lbs ❑ 40lbs ❑ 50lbs ❑ Other:
PUSHING/PULLING:	No more than: ❑ 2 hrs ❑ 4 hrs ❑ 6 hrs ❑ 8 hrs ❑ 10hrs ❑ Other: No more than: ❑ 10lbs ❑ 20lbs ❑ 30lbs ❑ 40lbs ❑ 50lbs ❑ Other:
MANUAL DEXTERITY:	❑ Left ❑ Right ❑ Limited use of hand(s) Not able to: ❑ Write ❑ Sort No more than: ❑ 2 hrs ❑ 4 hrs ❑ 6 hrs ❑ 8 hrs ❑ 10hrs ❑ Other:
REPETITIVE MOTION:	❑ Left ❑ Right ❑ Short periods ❑ Self paced No more than: ❑ 2 hrs ❑ 4 hrs ❑ 6 hrs ❑ 8 hrs ❑ 10hrs ❑ Other:
CLIMBING STAIRS/LADDERS:	❑ No Ladder Climbing ❑ No Stair Climbing ❑ Short Stair Flights
MEDICATION(S) CAUSING SEDATION/DROWSINESS:	
MISCELLANEOUS:	❑ No work with arms above shoulder level ❑ No operating mobile equipment ❑ No working near high speed / moving machinery ❑ Ground level work only ❑ No bending or twisting Not able to work in: ❑ Dust ❑ Cold Temperatures
WORKER STATUS:	❑ Fit for Regular Duties ❑ Fit for Modified Work ❑ Sedentary ❑ Light ❑ Medium ❑ Heavy Estimated Time of Return to Regular Work:

DATE OF REASSESSMENT:	

COMMENTS:

EMPLOYEE NAME (PRINT)	SIGNATURE	DATE

PHYSICIANS NAME (PRINT)	SIGNATURE	DATE

Modified Work Offer

DATE:	PROJECT:	PROJECT LOCATION:	PROJECT NUMBER:

CONTACT NAME:	CONTACT PHONE:	CONTACT FAX:

Please be advised that _____ (name) , _____ (Claim No.)

of Wellsite Geologists , who sustained _____ (injury)

on _____ (date) has been placed on modified work as of _____ (date)

In keeping with our policy to consider suitable duties for workers unable to perform their regular duties, we are offering the following modified work duties.

We will continually review your progress and adjust the length of this placement as required, based on relevant medical information. Your pay will remain at the normal rate.

During this modified work placement, you will be supervised by:

_____

If you have any concerns or difficulties, please notify your supervisor immediately.

We also request that you meet with _____ (name) _____ (position)

On a regular basis, at least weekly, to review your progress.

❑ **OFFER ACCEPTED** ❑ **OFFER DECLINED**

EMPLOYEE NAME (PRINT)	SIGNATURE	DATE

SUPERVISOR NAME (PRINT)	SIGNATURE	DATE

Personal Protective Equipment – Inspection (monthly)

This is in addition to the daily inspections

Owner/User of Equipment:_____ Date: _____

State not applicable if that is the case

Hard Hat	OK	Replace
CSA Approved		
Check for cracks and wear		
Do not put stickers (except those provided by our clients) on it		
Use Snell approved helmet on ATV and snow machine…always		
Coveralls	OK	Replace
Must be fire resistant		
All clothes worn under must be made of natural fibres		
Good condition (no rips or tears)		
Reflective stripes		
Safety Glasses	OK	Replace
CSA Approved		
Check for scratches		
Boots	OK	Replace
CSA Approved		
Steel toe and shank and chemical resistant		
Hearing Protection	OK	Replace
CSA Approved		
3 spare sets of plugs or 1 pair of earmuffs in vehicle		
Hand Protection	OK	Replace
Leather work gloves		
Chemical gloves (if required)		
Warm Weather Clothing	OK	Replace
Extra warm clothes all seasons		
Chemical Barriers	OK	Replace
Bug Spray		
Sunscreen		
Animal Protection	OK	Replace
Bear Spray – do not leave in vehicle		
Bear Bells		
First Aid Kit	OK	Replace
Has it been used?		
Clean, dry, and serviceable		
Fall Protection	OK	Replace
Check for wear		
Proper for the task		
Respiratory Protection	OK	Replace
Fit testing		
Proper for the task		

Submit this form monthly, only noting equipment that you have worn over the past month.

During daily inspections if a defect is noted immediately replace, if required.

Inventory of Assets – Value >$250

Item - description	Approx. Value	Noticeable Marks (Serial Numbers, etc)

Maintenance and Inspection Schedule

(include all Tools and Equipment)

Item - description	Schedule	Inspection	Maintenance
Vehicles (company & personal)	Daily	Pre-Trip	If needed
	3-4 months	Complete	Oil Change and Filter, if needed
Hand Tools	Daily	Pre-Use	Repair or replace, if defect noted

Vehicle / Equipment Maintenance Records

(filled out on an ongoing basis submitted annually)

Vehicle Make: _____ Vehicle Model: _____Vehicle Year: _____

Owner: _____

Date Vehicle first used for work: _____

Insurance Amount: _____ Expiry: _____
Is the vehicle insured for business use? Yes ❑ No ❑

Registration #: _____ Expiry Date: _____
(on your sticker)

Date	Mileage (kms)	Work Done To Vehicle

WALK AROUND YOUR VEHICLE

Pre-Trip Vehicle Inspection Report – Non NSC Vehicles					
Item #	Hazard Class	Date:			
		Mileage:			
		Inspector:			
		Vehicle ID:			
		Weather Conditions:			
		Inspection Item	**Condition**		**Action Taken**
1		Tire Pressure	FL	FR	
			RL	RR	
2		Tire Tread	OK / Not OK		
3		Windshield Condition	Cracked / Not Cracked		
4		Windshield Washer Fluid	OK / Low		
5		Wiper Blades	Good / Bad Condition		
6		Horn	OK / Not Working		
7		Lights	OK / Burnt Out		
8		Oil Level within Proper Range	Yes / No		
9		Transmission Fluid	OK / Low		
10		Radiator Fluid	OK / Low		
11		Brake Fluid	OK / Low		
12		Brake Check	OK / Needs Repair		
13		Emergency Brake Check	OK / Needs Repair		
14		Battery	Good / Low		
15		Scratches, Dents, or Body Damage	Yes / No		
16		License, Registration, and Insurance in Glove Box	Yes / No		
17		First Aid Kit	Yes / No		
18		Emergency Phone Number List	Yes / No		
19		Other			
20					
Hazard Class A – Major B – Serious C – Minor					

Comments

A- Major: Has the potential to cause a fatal or serious accident
B- Serious: Will gradually cause a problem (ie: brakes need changing in 4 months)
C- Minor: No significant consequence could happen (ie: scrape/dent on car)

Please complete and submit Inspection Reports

Journey Management Form

Name:_____ Date:_____

Passengers: _____ _____
_____ _____

Contact Person: _____ Phone Number:_____

Has an updated Road and Weather report been reviewed? YES NO

Has the route been clearly defined and mapped? YES NO

Is a Communication Device available in case of emergency? YES NO

Departure and Arrival time discussed with Contact person? YES NO

Have all Journey Risks been identified and discussed? YES NO

Will night-time driving be required? YES NO

Do you have the following Safety Supplies:

- First Aid Kit YES NO
- Blankets YES NO
- Food / Water / Money in case of emergency YES NO
- Is the vehicle properly equipped for the road conditions? (ie winter tires, 4x4, chains, air conditioning, etc) YES NO

Pre & Post Trip Inspections will be completed? YES NO
Only vehicles in acceptable condition may be driven

List any special considerations:

_____
_____
_____

Name of Driver:_____ Signature of Driver:_____
Name of Manager:_____ Signature of Manager:_____

Keep this record on file for at least 3 months from date of the Journey

Job Site Hazard Assessment and Control Measures

Date/Time: _____ Location: _____
Conducted By: _____ Client: _____

Do you have a First Aid Kit? YES / NO

Are you able to communicate with others (ie cell phone, radio)? YES / NO

Do you have a list of Emergency Numbers? YES / NO

Please list Personal Protective Equipment required:

IDENTIFIED HAZARDS

- □ Access/Egress
- □ ATV/ Snow Machine
- □ Confined Spaces
- □ Congestion
- □ Creek/Water Crossing
- □ Driving
- □ Electrical
- □ Energized Equipment
- □ Entanglement
- □ Environmental
- □ Equipment Backing
- □ Equipment Condition
- □ Excavation/Trench/Drilling
- □ Existing Underground Utilities
- □ Explosive Gases
- □ Fuelling Equipment
- □ H_2S Possible
- □ Hazardous Materials (WHMIS)
- □ Heavy Equipment
- □ Housekeeping
- □ Ignition Sources
- □ Lack of Oxygen
- □ Landowner Issues
- □ Lighting (or lack of)
- □ Manual Lifting
- □ Noise
- □ Not Properly Trained
- □ Overhead Power Lines
- □ Pinch Points
- □ Pits/Ponds
- □ Radiation (inc. NORMS)
- □ Rigging
- □ Scaffolds
- □ Slips/Trips/Falls
- □ Steep Slopes / Soil Stability
- □ Tools
- □ Toxic Gases (BTEX, CO, CO_2)
- □ Traffic/Detour
- □ Vibrations (excessive)
- □ Violence
- □ Weather-Related Hazards
- □ Wildlife/ Domestic Animals
- □ Working Alone
- □ Working at Heights
- □ Other

JOB HAZARD ASSESSMENT – CORRECTIVE ACTION

Hazard	Priority (low/med/high)	Recommended Action / Control	Action Taken By Whom

Everyone on site should participate in this hazard assessment; the results must be communicated to all workers on site. All people on site must sign below indicating that they are aware of the hazards and the control or elimination methods.

Name / Company	Name / Company	Name / Company

A new hazard assessment must be completed prior to work at all new job sites. Hazard Assessments must be repeated or updated weekly, or when a work process is introduced or changed.

Office Inspection Checklist

To be completed on the 1st of every month

Date: _____ Inspection Performed by: _____

General	Ok	Corrective Action Required	Comments/ Date Complete
Are broken chairs, desks, bookshelves & other furniture removed from the office?			
Is housekeeping at the time of inspection adequate? No slip, trip or fall hazards present.			
Are floors and aisles clear of materials & equipment?			
Are materials appropriately stored in the storage room?			
Is the storage room neat & tidy?			
Is the kitchen area clean & free of clutter?			
Is lighting adequate and in working order?			
Are washrooms in good working order?			
Are outside sidewalks and parking lots in safe condition?			
Fire Prevention, Emergency Exits & 1st Aid	**Ok**	**Corrective Action Required**	**Comments/ Date Complete**
Have the fire extinguishers been inspected within the past 12 months?			
Are the fire extinguishers accessible (not blocked or obstructed)?			
Are the exit doors clear of obstructions?			
Are the exit doors in good working condition?			
Are the exits properly marked, exit signs illuminated?			
Are overhead sprinkler/detectors clear of obstructions?			
Is all excess paper removed?			
Do the first aid kits have adequate supplies?			
Is the alarm in good working order?			
Last annual drill date_____			Must be within the last year
Electrical	**Ok**	**Corrective Action Required**	**Comments/ Date Complete**
Are there any broken plugs, sockets or switches?			
Are there frayed or damaged cords?			
Are outlets overloaded?			
Are extension cords attached together (not allowed)?			
Personal lamp, fans, space heaters in good condition?			

Please inform Management of any improvements or changes that need to be made. Prior to completing the office inspection review the prior months inspections to ensure all action items have been corrected.

When problem is rectified, please place a comment and the date in the comment section.

Shop Safety Inspection Form

Date: _____
Inspector: _____

All Actions must be addressed within a reasonable time frame.

Areas of Inspection Comments

Equipment:	***Comments/Action/Date***
☐ **Guards** on mechanical equipment	
☐ Proper **PPE** worn (gloves, goggles, ear plugs, etc.)	
☐ **Ladders** in good condition	
☐ **Tools** in good condition	
☐ **Eyewash** stations function properly, tested weekly, unobstructed	
☐ **Safety showers** function properly, tested monthly, unobstructed	
☐ **Compressed gas** cylinders secured properly	
Electrical and Fire:	
☐ **Power cords** (3-prong, good condition, commercial grade only)	
☐ **Power strips** w/ circuit breaker, no household extension cords	
☐ **Electrical panels** unobstructed	
☐ **18" clearance** from fire sprinkler heads	
☐ Nothing hanging from **sprinkler** heads, **pipes**, or **smoke detectors**	
☐ **24" clearance** from ceiling	
☐ **Alarm pull-stations and fire extinguishers** clearly identified and unobstructed	
☐ **Fire extinguishers** (tamper seals in place, tags show inspection <1 yr old, 3 ft clearance)	

Environment:

- ☐ Work area adequately **illuminated** _____
- ☐ **Temperature** within normal limits _____
- ☐ **Noise levels** within normal limits _____
- ☐ **Ventilation** (adequate, free from dust and fumes, vent grills clean) _____
- ☐ No signs of **water leaks** in ceiling tiles, floor or other areas _____

General:

- ☐ **Non-smoking** policy in effect
- ☐ **Aisles, stairwells, and exits** unobstructed
- ☐ **Emergency and exit lights** functioning
- ☐ **Evacuation maps** posted
- ☐ **Emergency telephone** numbers posted where they can be readily found
- ☐ **Floor** in good condition (no frayed carpet, loose tiles, slippery areas, etc.)
- ☐ No obvious **slip, trip, or fall** hazards
- ☐ **Spills** cleaned up and reported immediately
- ☐ **First aid kit** available and adequately stocked
- ☐ **Recycling and trash bins** orderly and emptied regularly _____
- ☐ **Custodial closets:** chemical containers labeled w/ chem. name, %, warnings, hazards, and manufacturer _____
- ☐ **MSDSs** current, available, and understood _____
- ☐ **Combustible** scrap, debris, waste stored safely and promptly removed from work areas _____

Other Comments:

_____

_____

_____

_____

Worksite Inspection Checklist Form

Conducted by:_____ Date:_____

All outstanding action items must be addressed within a reasonable timeframe

Personal Protective Equipment	**Y**	**N**	**NA**
Are hard hats, safety glasses, and steel toed boots being used?			
Is hearing protection available for personnel that may be exposed to noise?			
Is respiratory protection available for personnel and being used where required?			
Are safety harnesses, lifelines, and shock absorbing lanyards available?			
Are personnel using gloves when handling sharp or rough material?			
Is additional safety gear required being supplied and used?			

Comments:

Housekeeping: Slips, Trips, and Falls	**Y**	**N**	**NA**
Are walking and working surfaces free of debris?			
Are waste and trash containers provided and used?			
Is adequate lighting provided?			
Is temporary storage of materials and supplies done in an organized manner?			

Comments:

Fire Protection and Prevention	**Y**	**N**	**NA**
Are all flammable liquid containers clearly identified?			
Have proper storage practices for flammables been observed?			
Are extinguishers readily accessible and serviced regularly?			
Have gas cylinders been chained upright with valve caps securely fastened?			
Are full and empty cylinders labelled properly?			

Comments:

Worker Compliance / Systems	**Y**	**N**	**NA**
Are the proper permits in place and filled out correctly?			
Pre-Job Safety Meeting completed?			
Do workers understand the job scope?			
Are safe work practices being followed?			
Has an emergency plan been put in place and understood?			

Comments:

Tools: Hand and Power	**Y**	**N**	**NA**
Are tools free of any obvious defects?			
Are tools inspected for frayed or damaged cords?			
Are tools and cords properly grounded (ground pins in good condition)?			
Are the handles on all tools in good condition (not bent, splintered, or broken)?			
Are shields and guards in place and in good condition?			
Are air hoses tied off (including whip checks)?			
Are operators qualified and instructed to use tools?			

Comments:

Ladders, Scaffolds, and Platforms	Y	N	NA
Is the proper ladder being used for the job?			
Are the ladders in good condition (no missing or broken rungs)?			
Are there safety shoes/cleats on the bottom of the ladder?			
Are non-conductive ladders available for use around live wiring?			
Are ladders tied off at the top or otherwise secured?			
Are scaffolds tagged and built by competent workers?			
Are guardrails and decks in place?			
Are workers aware not to modify scaffolds?			

Comments:

Electrical	Y	N	NA
Are lockout devices available/used on circuits that could become energized?			
Are extension cords continuous without splices?			
Are GFCI's being used?			
Are working surfaces clear of cords (tripping hazard)?			
Outlets do not appear to be overloaded?			
Is additional safety gear required being supplied and used?			

Comments:

Other	Y	N	NA
Are barriers in place (tape, signs, etc)?			
Are clearances marked, where required?			
Are truck and equipment loads properly secured and transported?			
Are smoking areas clearly defined and followed?			
Is safety equipment reviewed and checked?			
Are WHMIS labels in place?			
Monitoring and supervision of workers in place and organized?			

Comments:

Item	Deficiency	Corrective Action	Date Completed

All hazards must be corrected immediately. Management will be informed of any outstanding hazards and an action plan will be implemented.

Daily Tail Gate Safety Meeting

1. **Site Hazards** – Review and update hazard assessment.

2. **Tasks** to be performed throughout the day_____

3. **PPE** – Hardhat, Nomex/ Proban Coveralls, Steel Toed Boots, H_2S meter, nitrile gloves, ear plugs, Appropriate clothes for the weather, others.

4. **Hospital** – The nearest hospital is _____(_____min drive)

5. **Transportation** – How will workers be transported?

6. **Equipment** (State location(s))
    - First Aid Kit
    - Eye Wash Stations
    - Fire Extinguisher

7. **First Aid** – Who is certified?

8. **Warning about toxic gases** –Is this an H_2S area? Are unknown gases likely to be present?

9. **Safe Driving** – Please be safe and courteous drivers.

10. **Smoking Areas**

11. **No alcohol or drugs**!!

Date:_____

Names (including signatures) of all attending the safety meeting

Record of Drill

Date/Time:_____ **Person Supervising Drill:**_____

Situation:_____

_____

_____

_____

_____

Workers Involved:

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

Communication:

Did you use an Alarm?	Yes / No
Was it wired to direct assistance?	Yes / No
Was the alarm company notified prior to drill?	Yes / No
Did the alarm work properly?	Yes / No

Evacuation:

Was an evacuation performed?	Yes / No
Did everyone leave the area?	Yes / No
Time taken to evacuate all workers, clients, visitors:	_____(minutes)
Did everyone go to the proper meeting area?	Yes / No
Was the evacuation orderly?	Yes / No

What was learned (what went good, what went bad)?

_____

_____

_____

_____

Areas Requiring Improvement:

_____

_____

_____

_____

Date of Follow – Up Safety Meeting to discuss Drill:_____

H_2S / 4 Head Monitor Bump Test Tracking Form

Unit Type: _____
Unit Manufacturer:
Unit Serial Number:
Last Calibration Date: _____

Date	Worker Responsible for Unit	Location of Bump Test	Pass/Fail

If bump test indicates the unit is not working properly the unit may not be used until a complete calibration has been performed.

Personal Monitor Readings

Date: _____
Unit #: _____
Location: _____

Workers: _____ _____
_____ _____
_____ _____
_____ _____

Record 4 Head Monitor Readings every 15 minutes

Time	O_2	CO	LEL	H_2S

Hazard Report Form

☐ **Class A** - conditions or practices with the potential for permanent disability

☐ **Class B** - conditions or practices with the potential for serious injury or property damage

☐ **Class C** - conditions or practices with the potential for minor injury

Description of Hazard:

Risk the Hazard Presents (to people, property, etc):

Location (be specific):

Action Needed (please note if intermediate steps were taken to alleviate the hazard):

Other Comments (continue on Back if necessary):

Immediate Corrective Action (describe who will correct the situation, what will be done and when):

Follow Up:

Reported By:_____

Date:_____

Working Alone Schedule

This form must be filled out each time a worker is alone. It may be filled out verbally over the phone as long as all contacts have been notified.

Date	
Name of Person Working Alone	
Contact Responsible for Above Person	
Alternative Contact (must be notified)	
Local Contact (operator or other workers)	
Likely End of the Day Destination	

A Hazard Assessment Form must be filled out PRIOR to Working Alone. Only begin or continue to work if the Hazard Assessment indicates that the task is not too risky for a lone worker.

Location	**Hazards** (from hazard assessment form)	**Check In Interval** (often 2 hours)	**Last Check In Time**

Note: All workers must call in for the last time once they have reached their final destination (hotel, home, etc).

The lone worker has one hour to call the contact person to tell them of any changes or to check in (unless the worker has asked this to be more stringent). If the worker fails to make contact within one hour, the following Overdue Worker Response Plan will be initiated:

- Attempt to contact the worker by cell phone, home number, hotels number, and/or radio.
- The client or other workers in the area (local contact) will then be notified and a plan to locate the worker will be initiated.
- Continual attempts will be made to contact the worker, also a call to the workers spouse, significant other, parents or other emergency contacts to see if they have heard from them and to keep them posted, will be made.
- The local contact will physically go to the locations specified on the contact sheet.
- Local hospitals will be called to see if the worker has been admitted.
- The local police or RCMP will be notified with a request for assistance.

When the worker is located all members involved in the search must be notified immediately.

Policy/Regulation Violation

Name of person making the complaint: _____

Name of person complaint is about: _____

Project: _____

Location: _____

Date of Violation: _____

Description of violation: (who/what/where/when) _____

_____

_____

_____

Signature: of person making the complaint: _____

Office Use Only

Offence: _____ First: ____Second: _____Third: _____

Agreed remedy to above violation: _____

_____

_____

_____

_____

_____

Comments: _____

_____

Date & Time to be in effect: _____

Worker Signature: _____Supervisor Signature: _____

Employee Warning Report

Employees Name: _____

Date of Warning: _____

Project: _____

Warning Issued By: _____

Type of Violation: ☐ Safety ☐ Other

Company Statement (Supervisor's Report)

_____
_____
_____
_____

Employee's Statement (Employee's Report)

☐ I agree with the company's statement

☐ I disagree with the company's statement for the following reasons:

_____
_____
_____
_____

I have entered my statement for the above matters.

Employee Signature:_____ Date_____

☐ I would like to receive a copy of this statement for my records.

PLEASE BE AWARE THAT THIS REPORT WILL BE KEPT ON FILE AT THE HEAD OFFICE, AND THE ISSUE MAY BE DISCUSSED AT A COMPANY HEALTH AND SAFETY MEETING IN THE FUTURE.

Work Refusal Investigation

1. What was the nature of the (perceived) Hazard? _____
_____
_____
_____

2. How many workers refused to work?_____
Name:_____ Position: _____
Name:_____ Position: _____
Name:_____ Position: _____
Name:_____ Position: _____

3. How many workers who refused to work were exposed to the (perceived) Hazard? _____

4. How many workers who were exposed to the (perceived) hazard continued to work? _____

5. How many workers who did not refuse to work were prevented from working by the refusal?___

6. How many working hours were involved in the work refusal? _____HRS.

7. How long did the workers work with knowledge of the (Perceived) Hazard? _____

8. Was the supervisor aware of the (perceived) hazard before the refusal?_____
How long before? _____

9. Did the worker(s) report directly to the supervisor? Yes ( ) NO ( )

Date: _____ Time:_____

If NO, Who was the refusal reported to? _____

Date: _____ Time:_____

10. Was the (perceived) hazard different from actual conditions? Yes ( ) No ( )

Describe _____
_____

11. Describe corrective action: _____

12. Was the corrective action mutually agreed upon by everyone involved in the investigation?
Yes ( ) No ( )

If NO, why not?_____
_____
_____

13. Persons involved in investigation?

Name: _____ Position:
Name: _____ Position:
Name: _____ Position:
Name: _____ Position: _____

14. Was the corrective action satisfactory to the worker(s) who refused the work? Yes ( ) No ( )
If NO, why not? _____

_____

_____

15._ Was the refusing worker(s) assigned to other work? Yes ( ) No ( )

What was it? _____

Was the rate of pay changed? Yes ( ) No ( )

Was any disciplinary action taken Yes ( ) No ( )

16._ Did other worker(s) carry on with the work after the investigation and corrective action (if required)? Yes ( ) No ( )

Name: _____ Position: _____
Name: _____ Position: _____
Name: _____ Position: _____
Name: _____ Position: _____

Were the replacement worker(s) informed of all the circumstances of the work refusal? Yes ( ) No ( )

17._ Were agencies outside of Wellsite Geologists involved in the work refusal? Yes ( ) No ( )

If YES, Who were they and what was their involvement? _____

_____

_____

_____

_____

_____

Date: _____ Time: _____

Who notified the outside agency? _____

Date: _____ Time: _____

What was their opinion regarding the (perceived) hazard? _____

_____

_____

18. Recommendation to prevent another occurrence of this nature: _____

_____

_____

Who is responsible to implement the recommendations? _____

_____

Completion Date: _____

Supervisor: _____ Date: _____
(Signature)

Site Manager: _____ Date: _____
(Signature)

Hazard / Near Miss Form

A Near Miss Event is one that had a likelihood of resulting in injury or property damage but did not because of luck or some other intervening factor. Near misses are unique because they give us a second chance to correct dangerous behaviors or conditions before they result in future injury or property damage. A near miss may also highlight the importance of PPE, safety rules and safety procedures.

(Completed by Worker Reporting Hazard or Near-Miss)

Description of Hazard or Near-Miss:

_____
_____
_____
_____
_____
_____

Precise Location:

_____

Management Representative to whom Hazard or Near-Miss has been Reported:

_____

Date of Report: _____

Name of Person Reporting: _____

Part 2 (Management Representative to Complete)

Name of Management Representative: _____

Corrective Action for Hazard or Near-Miss Reported	Person Responsible	Completion Date

Signature of Reporting Employee: _____.Date:
Signature of H&S Representative: _____ Date:
Signature of Management Representative: _____ Date: _____

Accident/Incident Investigation Report Form

This must be submitted as soon as practical or within 24 hours after the incident.

Date and Time of Occurrence: _____

Location of Occurrence: _____

_____

_____

EVENT TYPE ☐ Injury ☐ Property Damage ☐ Illness

☐ Fire ☐ Near Miss (incident) ☐ Other

WCB Report Submitted: ☐ YES ☐ NO

Name of Employee(s): _____

What type of Injury/Incident?

_____

_____

Condition at the time of accident/incident (weather, status of job, etc.)? What happened immediately prior to the accident/incident?

_____

_____

_____

_____

Description of accident - What equipment, tools, materials, etc. were involved? What job was being done? Who else was involved? What happened?

_____

_____

_____

_____

_____

What were the contributing and root causes of the incident?

_____

_____

_____

_____

Recommended action(s) to prevent re-occurrence:

_____

_____

_____

_____

If the incident were to happen again, describe how severe injuries and damages could be:

Witness(es):

Witness Statement(s):

Diagram:

Investigated By (name and title): _____ Date: _____

Follow-Up Review By (name and title): _____ Date: _____

File Closed By (name and title): _____ Date: _____

First Aid Record

Date of injury or illness:_____/_____/_____ Time:_____ AM
Day Month Year PM

Date injury or illness **REPORTED :** __/_____/____ Time:_____ AM
Day Month Year PM

Full name of injured or ill worker: _____

Description of the injury or illness:

_____
_____
_____

Description of where the injury or illness occurred/began:

_____
_____
_____

Cause of the injury or illness:

_____
_____
_____

First aid provided? ☐ Yes ☐ No

Name of first aider: _____

First Aider Qualifications:

Emergency First Aider ☐
Standard First Aider ☐
Advanced First Aider ☐
Nurse ☐
Emergency Medical Technician-Paramedic ☐
Emergency Medical Technician ☐
Emergency Medical Responder ☐

Describe first aid provided:

_____
_____
_____

Copy provided to worker ☐ Copy refused ☐ Injured worker initials _____

Keep this record confidential and retain for at least 3 years from date of injury/illness is reported

Statistics

Reporting Year:_____

	Ave. Number of Employees	Work Hours	Fatalities	Lost Time Injuries	Lost Work Days	Restricted /Modified Work Cases	Medical Aids	First Aids	Near Misses	Kilometres Driven	Vehicle Accidents	Property Damage
January												
February												
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												
Total												

Safety Activity Summary

For the Period Ending: _____

☐ **Monthly** ☐ **Quarterly** ☐ **Yearly**

1. Number of Workers Hired: _____
   Number of Completed Orientations _____

2. Number of Tool Box Meeting Scheduled: _____
   Number Conducted: _____
   Percentage Attendance: _____

3. Number of Formal Inspections Scheduled: _____
   Number Completed: _____
   Total Unsafe Acts/Conditions Identified: _____
   Number Corrected: _____
   Number Outstanding: _____

4. Number of Incidents: _____
   Damage Only: _____
   Injury Only: _____
   Injury and Damage: _____
   Near Miss _____

Number of Investigations _____
   Completed: _____
   Outstanding: _____
Number of Recommendations Made _____
   Completed: _____
   Outstanding: _____

Comments:

_____
_____
_____
_____

Manager's Signature: _____

Date: _____

Safe Job Procedures

Annual Review

Safe Job Procedures	Development		Review		Review	
	Date (M/D/Y)	By Whom	Date (M/D/Y)	By Whom	Date (M/D/Y)	By Whom

Safe Job Practices

Annual Review

Safe Job Practices	Development		Review		Review	
	Date (M/D/Y)	By Whom	Date (M/D/Y)	By Whom	Date (M/D/Y)	By Whom

Year End Injury Summary

Year:	Personal Injury Cases			
Month	**Lost Time Cases**	**Medical Referral**	**Days Lost**	**No Loss Incidents**
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Totals:				
Manager's Signature:_____			**Date:_____**	

Note: This form must be completed on a yearly basis and retained in records.