2022

CONSTRUCTION FORMS ALBERTA

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1.0 ACCIDENT – INCIDENT INVESTIGATION FORM

INCIDENT OCCURRED: LOCATION & DATE

Location of Accident or Incident:	
Date of Incident mm-dd-yy:	Time AM ❒ PM ❒:

INJURED PERSON

Last Name (print)	First Name (print)	Phone Number

NATURE OF INJURY/INJURIES

1.
2.

WITNESSES

Last Name (print)	First Name (print)	Phone Number

ACCIDENT / INCIDENT DESCRIPTION

Briefly describe what happened, including the sequence of events preceding the incident (attach description to this form if more room is required:

STATEMENT OF CAUSES & CONTRIBUTING FACTORS

List any unsafe conditions, acts, or procedures that in any manner contributed to the accident / incident:

RECOMMENDATIONS

Recommend Corrective Actions(s)	Action by Whom	Action Date By
1.		
2.		
3.		

Investigation Completed By: Signature: Date:

_____ _____ _____

Investigation Completed By: Signature: Date:

_____ _____ _____

2.0 FIRST AID RECORD FORM

Name:	Occupation:	Department:
Date of Injury/Illness (D/M/Y):	Time of Injury/Illness (AM/PM):	
Date and Time of Injury Reported (D/M/Y - AM/PM):		

Description of how the injury, exposure, or illness occurred *(print clearly - what happened?)*

Description of the nature of the injury, exposure, or illness *(print clearly - what you see – signs and symptoms)*

Description of treatment given *(print clearly)*

Interventions: ☐ CPR ☐Airway Cleared ☐ Airway Maintained ☐ Ventilated ☐ Controlled Bleeding

Any Witnesses?: ☐ Yes ☐ No If yes, please provide name(s): _____

Recommendations (Check): ☐Return to Work ☐Medical Aid ☐Follow Up – When? _____

Transported By (Check): ☐Ambulance ☐Taxi ☐Company Vehicle ☐ Other – Explain _____

Graduated Return to Work: ☐ Alternate Duty Options ☐ Return to Work Form – Medical Aid ☐Workers Supervisor Informed

Provided Worker Handout: ☐Yes ☐No If yes, which form: _____

OFAA Name (Please Print):	OFAA Signature:
Patient Name (Please Print):	Patient Signature:

3.0 NEW AND YOUNG EMPLOYEE SAFETY ORIENTATION FORM

Name: _____ Age: _____ Date: _____

Position as hired: _____

Do you have First Aid Certification? Yes ❒No ❒ If **yes**, what level: _____

Do you or are you required to where Prescription Glasses or Contact Lenses?
Yes ❒ No ❒ If **yes**, what kind: _____

Do you have any Allergies? Yes ❒ No ❒ If **yes**, what: _____
(Please include any special medication you must take for your allergies)

Do you take any Special Medications? Yes ❒ No ❒ If **yes**, what: _____
(Health condition, where medication is prescribed by your doctor i.e. heart condition) – the answer to this question is 'optional'

Do you have any physical/health related disablement(s) that may be aggravated, and/or that may prevent you from performing certain job tasks or duties while employed with Build & Gain Contractors INC.?
Yes ❒ No ❒ If **yes**, what:

_____

Please **initial inside each check box** for each applicable safety policy/procedure discussed during the safety orientation. By initialing each box, you verify that you understand and comprehend Build & Gain Contractors INC. 's Occupational Health and Safety policies and safe work procedures.

1. Health & Safety Policy	17. Housekeeping
2. Company Joint Health and Safety Committee Information	18. Tools Machinery & Equipment
3. Supervisor Contact Information	19. Right to Refuse Unsafe Work
4. Emergency Contact Information	20. Right to Participate
5. WHMIS	21. Right to Know
6. Material Safety Data Sheets	22. Safe Sharps Disposal
7. First Aid Procedures	23. No Smoking
8. Eye Wash Stations	24. Drug & Alcohol Use
9. Emergency Evacuation Procedures	25. Workplace Violence
10. Personal Protective Equipment (PPE)	26. Working Alone
11. Respiratory Protection	27. Horseplay
12. Hearing Protection	28. MSI's
13. Hazard Reporting	29. Back Safety
14. Harassment and Bullying	30. Fall Protection & Ladder Safety
15. Lock Out Safety	31. Scaffolding Safety
16. Warning Signs	32. Yellow Caution Tape / Red Danger Tape
	33. Excavating Safety

I, _____, understand and will adhere to all applicable Build & Gain Contractors INC.safety policies and safe work procedures as outlined and discussed in this new and young employee safety orientation session.

Employee Signature: _____ Date: _____

Manager and/or Supervisor **(please print name and sign):**_____

4.0 SUB-CONTRACTOR SAFETY ORIENTATION FORM

Contractor Company Name: _____

Enclosed is the Build & Gain Contractors INC. health and safety program. This program addresses Occupational Health & Safety requirements for all sub-contractor and/or contractors hired for any particular project(s). During the performance of any contracted work the Alberta OHS Regulations Occupational Health and Safety Act, Regulations & the requirements of the Build & Gain Contractors INC. health and safety program must be strictly adhered and observed. There are no exceptions.

Failure to follow all company health and safety rules, safe work procedures and safety policies and any violation of these rules, procedures and policies:

MAY RESULT IN DISCIPLINARY ACTION BY Build & Gain Contractors INC.

Please **initial inside each check box** for each applicable safety policy/procedure discussed during the sub-contractor orientation. By initialing each box, you verify that you understand and comprehend Build & Gain Contractors INC. health and safety policies and safe work procedures.

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2. Company Joint Health and Safety Committee Information	18. Tools Machinery & Equipment
3. Supervisor Contact Information	19. Right to Refuse Unsafe Work
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14. Harassment and Bullying	30. Fall Protection & Ladder Safety
15. Lock Out Safety	31. Scaffolding Safety
16. Warning Signs	32. Yellow Caution Tape / Red Danger Tape
	33. Excavation Safety

I, _____, understand and will adhere to all applicable Build & Gain Contractors INC. written safety policies and safe work procedures as outlined and discussed in this sub-contractor safety orientation session.

Sub-Contractor Signature: _____Date: _____

Manager and/or Supervisor**:** _____

5.0 FIT TEST RECORD FORM

Employee Name: _____ Date:_____

Occupation:_____ Male ❒ Female❒

Was the employee **CLEAN-SHAVEN** prior to issuing of this respirator? Yes ❒ No ❒

Comments: _____

Type of Respirator

Manufacturer:	3M ❒	North ❒		
Type:	Half Mask ❒	Full Face ❒	Air-Line ❒	SCBA ❒
Size:	Small ❒	Medium ❒	Large ❒	X-Large ❒
Model:	_____			

Comments: _____

Type of Filters / Cartridges

Manufacturer:	3M ❒	North ❒
Type:	Hepa-Filter ❒	Organic Vapour ❒
Model:	_____	

Comments: _____

Qualitative Fit Test

Positive Pressure Check:	Pass ❒	Fail ❒	
Negative Pressure Check:	Pass ❒	Fail ❒	
Testing Agent:	Isoamyl Acetate ❒	Pass ❒	Fail ❒
	Bitrex ❒	Pass ❒	Fail ❒
	Sodium Saccharin ❒	Pass ❒	Fail ❒

Comments: _____

Fit Test Conducted By: _____

Employee Signature: _____

6.0 FALL PROTECTION WORK PLAN FORM

This fall protection work plan must be reviewed, completed and signed prior to starting work in an area where a fall of 7.5 meters (25 feet) or more may occur.

Jobsite Address:	Start Date of Job:
Job Task(s) Description:	
Job Site or Work Area Description:	

Identify Potential Fall Hazards and/or Other Hazards

- ❑ Floor Openings
- ❑ Skeletal Framing
- ❑ Ladders
- ❑ Roof Slope
- ❑ High Voltage Power Lines
- ❑ Scaffold Erection & Dismantling
- ❑ Stairways
- ❑ Swing Fall
- ❑ Wall Opening
- ❑ Machinery and Equipment

Additional Information (Description of Above Hazards?):

_____

Ladder Safety:

- ❑ FIRM LEVEL BASE
- ❑ SET UP 4:1 (Vertical: Horizontal)
- ❑ EXTENDED 3 FT PAST EDGE OF ROOF
- ❑ LADDER SECURED

Fall Protection System to be used:

- ❑ FALL RESTRAINT
- ❑ WORK PLATFORM
- ❑ FALL ARREST
- ❑ SCAFFOLD
- ❑ GUARDRAILS (Temporary)
- ❑ CONTROL ZONE (Monitor)

WORKSITE ROOF/FALL HAZARD DIAGRAM:

Methods of Protecting Workers from Hazards (C.S.A. Approved Equipment)

- ❑ HARD HATS
- ❑ SAFETY GLASSES
- ❑ WARNING SIGNS
- ❑ FOOTWEAR
- ❑ TOE BOARDS
- ❑ OTHER (Identify Below)

Additional Information (Methods of Protection?):

Adequacy of Anchor Points:

- ❑ Professionally Engineered
- ❑ Existing Engineering
- ❑ Manufacturer's Specification
- ❑ Other (Identify Below)

Additional Information (Locations of Anchor Point?)

- ❑ 5000 lb. Anchor (Fall Arrest)
- ❑ 800 lb. Anchor (Fall Restraint)

Where?

Rescue and/or First Aid (Prior to Accessing Height):

- ❑ First Aid Attendant / Equipment
- ❑ Bin Placement / Barricades in Place
- ❑ Elevators / Stairs
- ❑ Fire Department Written Agreement

Additional Information (Rescue and/or First Aid Procedures?):

There is a 33 foot ladder on site exclusively for rescue purposes? Workers have been trained in the procedure to get the ladder and assist fallen worker?

By signing below I acknowledge that I have reviewed with my Supervisor and understand fully, the fall protection and other health and safety requirements and procedures for this work site.

EMPLOYEE NAME	SIGNATURE	DATE

Supervisor Signature: _____ Date: _____

7.0 FALL PROTECTION EQUIPMENT INSPECTION CHECKLIST

Print Name: _____ Date of Inspection: _____

Signature: _____ Other: _____

This checklist is a guideline for your daily fall protection equipment inspection. You have been trained on how to thoroughly inspect your fall protection equipment to ensure your personal safety.

- Put a check mark ☑ in the boxes if the corresponding equipment is in good working order.
- Put a ☒ in the boxes if the corresponding equipment is **NOT** in good working order.
- **REPORT ALL DEFECTIVE EQUIPMENT TO YOUR SUPERVISOR AND ENSURE ALL DEFECTIVE EQUIPMENT IS DESTROYED AND/OR TAGGED OUT OF SERVICE.**

FULL BODY HARNESS	☑ ☒	**LANYARD**	☑ ☒
Tags and Labels: be sure model and serial numbers are clear as well as CSA approval and manufacture date.		Webbing: no fraying, cuts, burns or chemicals. Stitching is good. No knots. Wear indicators if present.	
Webbing: webbing frayed, cut or burned. Wear indicators good. No glue, paint or other chemicals.		Snap Hooks: bent, cracked, corroded or twisted hook. Lock functioning. Springs working.	
Tongue, Grommets and Buckles: not bent, cracked or corroded. All parts move freely. No distortion or sharp edges. Grommets good, none missing or damaged.		Shock Absorber: check for signs for signs of deployment, shock loading. Stitching where pack is attached.	
Seams or Stitching: stitching loose, pulled, ripped or worn. Check load bearing and attachment stitching carefully.		**LIFELINE**	☑ ☒
D Rings: not worn, bent or deformed. No rough or sharp edges. Rings pivot freely. Check closely for cracks.		Rope: frayed, rotted, cut or fuzzy. No knots. Discoloration from exposure or chemicals.	
Rivets & Straps Keepers: In good shape, not loose. Strap keepers move, not broken or missing.		Diameter: matches the rope grab and is uniform throughout	
Clean and Oil Free: Check with supervisor if in doubt of condition.		Attachment to Snap Hook: Original from manufacturer. Thimble good.	
Tool Holders: Safe and good shape, no modifications or damages.		Rope Grab: functioning properly. Check gate, locking pin, safety latch worn out teeth on cam, springs. Do hand test.	
SELF RETRACTING LIFELINE	☑ ☒	**HORIZONTAL LIFELINE**	☑ ☒
Line: pull out and inspect cable for bends, frayed strands, evidence or excessive wear. Retrieval / retraction mode functioning properly. Pull test to make sure it catches. Check for shock loading indicator. Attach directly to dorsal D ring.		Engineered: specifically designed and engineered for fall protection. Check for capacity (how many workers). Ask Supervisor to confirm if unsure.	

Type: _____ S/N: _____

Type: _____ S/N: _____

Type: _____ S/N: _____

Comments:

_____

Supervisor Signature: _____ Date: _____

8.0 CREW TOOL BOX TALK FORM

Date : _____ **Location:** _____

Topics Covered (Please Print Clearly):

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

Was a safety video(s) used for the tool box talk? ☐ Yes ☐ No

Name of Video(s):_____ Length (min):_____

Were any handout(s) given to the employees during this tool box talk? ☐ Yes ☐ No

Handout(s):_____

*** Please attach any handouts or any other material used in the toolbox talk with this form ***

Employees Present at Crew Toolbox Talk:

Print Name:	Signature:	Print Name:	Signature:

Crew Talk Conducted By: _____ Signature: _____

9.0 LOCK OUT FORM

Preparation for Shut Down

1. Identify equipment to be shut down: _____
2. Location in facility: _____
3. Procedures to notify all **affected employees**: _____
   _____
4. Identify **all** power sources:

a) Electrical: _____

b) Air: _____

c) Steam: _____

d) Hydraulic: _____

e) Gravity: _____

f) Other: _____

5. Identify lockout/tagout devices to be used: _____
   _____
   _____
   _____

Shut Down

Description of the shutdown procedures: _____
_____
_____
_____

Isolation

Procedures for isolation of equipment from **all** power sources: _____
_____
_____

Lockout/Tagout Device Application

Procedure for locking out or tagging out equipment: _____
_____

Release of Stored Energy

Procedures for the release of stored energy (where applicable): _____

Verification of Isolation

Procedures to ensure that equipment is isolated from **all** power sources: _____

Start-Up

1. Visual inspection of the machine and equipment. Ensure all tools have been removed. Return guards to place.

2. Notify all **affected employees** and **other** employees of the start-up.

3. Remove all lockout/tagout devices and restore power.

10.0 TRAINING RECORD FORM

Company:			
Title of Program:			
Date of Training:		**Certificate Issued:**	[Yes/No]
Instructor's Name:			
Location of Training:			

Print Name	Signature	Successfully Completed	
		Yes	No

11.0 CONFINED SPACE ENTRY PERMIT

NAME OF SPACE:		
DATE OF ENTRY:	TIME ENTRY START:	
DATE OF EXPIRY:	TIME PERMIT EXPIRES:	
NAME OF STANDBY PERSON (1)	TIME START:	TIME STOP:
NAME OF STANDY PERSON (2)	TIME START:	TIME STOP:

LOCATION OF SPACE:
DESCRIPTION OF SPACE:
DESCRIBE WORK TO BE DONE:

SIGNATURE – CONFINED SPACE SUPERVISOR (1):

_____

SIGNATURE – CONFINED SPACE SUPERVISOR (2) :

_____

ATMOSPHERE: ❑ **HIGH HAZARD** ❑ **MODERATE HAZARD** ❑ **HIGH HAZARD**

COMMUNICATION: ❑ RADIO ❑ VERBAL ❑ VISUAL
LIGHTING : ❑ ADEQUATE ❑ EXPLOSION PROOF
LOCKOUT REQUIRED: ❑ YES ❑ NO

If, YES. Lockout – please list all machinery and equipment locked out: _____

PERSONAL PROTECTIVE EQUIPMENT:

❑STEEL TOE BOOTS
❑RUBBER BOOTS
❑TYVEK COVERALLS (IMPERMEABLE)
❑RUBBER COVERALLS (CHEMICAL)
❑HARD HAT
❑SAFETY GOGGLES
❑FACE SHIELD
❑RUBBER GLOVES (IMPERMEABLE)
❑NEOPRENE GLOVES (CHEMICAL)
❑HALF MASK RESPIRATOR
❑ORGANIC VAPOR CARTRIDGES
❑SCBA
❑FULL BODY HARNESS / LIFELINE / TRIPOD

AIR MONITOR USED:	CALIBRATION DATE:	CALIBRATION DUE DATE:

TIME:	TESTER INITIALS:	OXYGEN (min 19.5% - max 23%)	FLAMMABLE/ EXPLOSIVE (max <10% of LEL)	CARBON MONOXIDE (max 8hr average <25ppm)	HYDROGEN SULFIDE (ceiling limit <10ppm)	OTHER: _____

I hereby certify that all required hazard controls are in place, that air monitoring is being conducted as required and results show that the atmosphere is acceptable for entry, and that all required information is documented on this permit.

Tester Signature: _____ Date: _____

Write a "/" each time the named worker enters the space. Write a "\" each time the named worker exits the space – **FORMING AN "X" FOR A COMPLETED ENTRY/EXIT (X)**

Standby Person's Signature (1): _____ Standby Person's Signature (2): _____

12.0 AERIAL WORK PLATFORM LIFT: PRE-SHIFT INSPECTION CHECKLIST

The pre-shift inspection shall be performed prior to each day's or shift's use of the aerial platform lift by an authorized and trained operator of the lift. Documentation of the inspection shall be maintained by Build & Gain Contractors INC., with a copy of the most recent inspection document stored on the lift. If there are any of these items that are not satisfactory place the lift out of service and report to your Supervisor immediately.

Make of Lift: _____ Model of lift: _____ Serial #: _____

Operators Name: _____ Date of Inspection: _____

Item Inspected	Okay	Not Okay	N/A
Operating controls	☐	☐	☐
Emergency controls	☐	☐	☐
Safety devices	☐	☐	☐
Personal protective devices	☐	☐	☐
Pneumatic system (leaks)	☐	☐	☐
Hydraulic system (leaks)	☐	☐	☐
Fuel system (leaks)	☐	☐	☐
Cables	☐	☐	☐
Wiring harness	☐	☐	☐
Loose/missing parts (locking pins/bolts…)	☐	☐	☐
Tires and wheels	☐	☐	☐
Placards and Warnings	☐	☐	☐
Operational Manual	☐	☐	☐
Outriggers/Stabilizers	☐	☐	☐
Guardrail system and locking gate	☐	☐	☐
Other items	☐	☐	☐

Comments:

_____

_____

_____

Operators Signature: _____ Date: _____

13.0 FORKLIFT: PRE-SHIFT INSPECTION CHECKLIST

Date:	Supervisor Name:	Company Name:
_____	_____	_____
Make and Model:	**Model #:**	**Hour Meter Reading:**
_____	_____	_____

BEFORE ENGINE START-UP:

Visual Walk Around Items	OK	NO	Comments:
Walk around inspection (warning decals, capacity plate, etc.)			
Forks/Locking Pins, Carriage, Mast			
Wheels, Tires & Lug Nuts (Condition and Pressure)			
Transmission (Check Oil Levels/Leaks)			
Engine Oil (Check Oil Level/Leaks)			
Fan Belts			
Air Filter			
Radiator (Check Coolant Level/Leaks)			
Hydraulic (Check Oil Level/Leaks)			
Fuel (Level and Secure)			
Over Head Guard			
Seat and Seatbelt			

AFTER ENGINE START-UP:

Engine Start-up Items	OK	NO	Comments:
Engine (Sound Normal?)			
Instrument Panel (Normal Readings?)			
Exhaust System (Leaks or Excessive Smoke?)			
Wipers and Lights (Do They Work?)			
Horn and Back-up Alarm (Do They Work?)			
Check all Hydraulic Controls (lift/lower system, tilt, side-shifter, etc)			
Transmission and Clutch (Direction and Speed Control)			
Brakes (Emergency Brake and Service Brakes)			
Steering			

Additional Comments (REPORT ANY DEFECTS TO YOUR SUPERVISOR IMMEDIATELY!):

_____

_____

_____

Operator Name: _____ **Operator Signature:** _____

14.0 FIELD LEVEL HAZARD ASSESSMENT FORM

This purpose of this assessment is to identify 'day-of-the-job' hazards associated with work tasks, to ensure hazards are controlled prior to starting work. Complete this assessment prior to the start of each new service request or when conditions of work have changed. Always check the condition of all tools and equipment and your work area for hazards *prior to* starting work. Provide completed copies of this form to your Supervisor.

WORK LOCATION:

DESCRIPTION OF JOB OR TASK:

SUPERVISOR IN CHARGE:	**PHONE/CELL:**

ASSESSMENT DATE (D/M/Y):	**COMPLETED BY:**

POTENTIAL HAZARDS (Check all that apply and add others as required if)

☐ Confined Space	☐ Extreme heat / cold	☐ Mould	☐ Obstructions	☐ Fall hazards
☐ Working Alone	☐ Noise	☐ Electrical	☐ Slip/Trip Hazards	☐ Unsafe tools/equipment
☐ Awkward postures or lifting	☐ Asbestos	☐ Lighting	☐ Mechanical	☐ Other: _____
☐ Hazardous gases/chemicals	☐ Sharp objects	☐ Animal droppings	☐ Entrapment	☐ Other: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____

OTHER HAZARDS OR INFORMATION:

REQUIRED HAZARD CONTROLS (**Check** all that apply and add additional controls in the available space).

Lockout tag out procedure	☐	Mechanical ventilation	☐
Hard hat	☐	Ladders for safe access and egress	☐
Protective gloves	☐	Mechanical aids (dolly etc.)	☐
Respirator	☐	Atmospheric testing	☐
Eye protection	☐	Emergency or rescue procedure	☐
Protective footwear	☐	Scaffolds (Inspected and tagged)	☐
Hearing protection	☐	Work Permit	☐
Coveralls	☐	Additional training	☐
Pedestrian Barricades	☐	Machine guarding	☐
Stand by worker	☐	Check in protocol with office or	☐
Confined Space Entry Procedures	☐	Fire extinguisher	☐
Additional Lighting (e.g. Flashlight)	☐	Other	☐
Communication device	☐		☐
Fall protection	☐		

Additional Information or Comments:

Supervisor Signature: _____ Date: _____

15.0 INCIDENT REPORT FORM

Check all boxes that apply:			
☐ Hazard	☐ Close Call/Near Miss	☐ Property Damage	☐ Injury

Date of incident or hazard report:		Company:	
Date reported:		Location:	
Reported by:		Type of job:	
Witness(es):		FA attendant (if applicable):	
Description of the hazard or incident:			

Hazard or Incident Type (check)	
Immediate threat to life	
Potential injury	
Ergonomic (MSD) hazard	
Minor hazard-injury unlikely	
Property Damage	
Other :	

Hazard or Incident Classification (check)	
Road condition	
Timber	
Damaged equipment	
Slip, trip or fall	
Temperature	
Fire hazard	
Chemical	
Machine guard	
Damaged or improper PPE	
Electrical	
Other:	

The Problem	Corrective Action	Who to do?	By when date?	Done date

Is an incident investigation required? ☐ **Yes** ☐ **No**

Supervisor: Date:

16.0 WORKING ALONE FORM

Definition

Alone

Working by yourself with no other people in the vicinity.

Isolation

Working in the same general area with a partner or another crew, but will not be in contact with the other person or crew for an extended amount of time.

Person Working Alone

- The person who will be working alone (the lone worker) must designate a contact person to check in with on a pre-planned schedule. The check in will be every _____ hours plus at end-of-shift.
- The lone worker must carry a functioning communication device, such as a satellite transceiver, two-way radio, satellite phone, cell phone or combination thereof plus the contact information for the contact person.
- The designated contact person must have a copy of this working alone procedure and any applicable ERP, contact information, locations and/or maps necessary for rescue of the lone worker.
- The designated contact person must record the time of each contact with the lone worker.
- If the lone worker fails to check in, then the contact person must initiate search procedures after _____ hours. See Missing Worker section of company Emergency Response Plan.

Person Working in Isolation

If two people are working on the same opening, or in the same immediate area, both should carry a functioning communication device and check in with each other on a predetermined schedule:

_____

If neither person has a functioning communication device then visual contact must be made on a predetermined schedule at the predetermined location:

_____.

Supervisor Responsibilities

The supervisor has:

1. Identified hazards to the worker
2. Managed the identified risks from hazards
3. Trained the contact person in responsibilities including emergency response.
4.

Working Alone or In Isolation Checklist

Date(s): _____

Worker Name: _____ **Working Location:** _____

Contact Person Name: _____ **Radio Frequency 1** _____

Radio Frequency 2 _____

Emergency Contact Type: _____ **Emergency Contact Phone:** _____
(family, supervisor, etc.)

Frequency of Contacts: _____

Monday		Tuesday		Wednesday		Thursday		Friday	
Time	**Check**	**Time**	**Check**	**Time**	**Check**	**Time**	**Check**	**Time**	**Check**
8:00 AM	☐	8:00 AM	☐	8:00 AM	☐	8:00 AM	☐	8:00 AM	☐
10:00 AM	☐	10:00 AM	☐	10:00 AM	☐	10:00 AM	☐	10:00 AM	☐
12:00 PM	☐	12:00 PM	☐	12:00 PM	☐	12:00 PM	☐	12:00 PM	☐
2:00 PM	☐	2:00 PM	☐	2:00 PM	☐	2:00 PM	☐	2:00 PM	☐
4:00 PM	☐	4:00 PM	☐	4:00 PM	☐	4:00 PM	☐	4:00 PM	☐
End of shift		End of shift		End of shift		End of shift		End of shift	

Name of Person Conducting Checks: _____

Signature of Person Conducting Checks: _____

17.0 BULLYING AND HARASSMENT COMPLAINT FORM

Name of person making the complaint:	Company:
Name of person complaint is against:	Company:
Date of complaint:	Location:
Date of investigation:	Person(s) investigating:

Person interviewed	**Other people involved** (e.g., alleged bully, witnesses)	**Description of the situation** (dates, words, actions, etc.) **and impact** (e.g., humiliated, intimidated)

Based on the investigation, did workplace bullying and harassment occur?

Yes ☐ No ☐

Reason(s) for this conclusion

Supervisor/Manager Signature:	Date:

Copies: person making complaint, manager,

18.0 EMERGENCY EVACUATION DRILL FORM

Year	Month	Day	Sector	Scenario	Involves*

Scenario description*:*

**Involves – Fire Drill Evacuation; Actual Fire; "Supervisor" had a heart attack; "Worker" had heat exhaustion.*

Debrief – what worked well:

Debrief – what needs improvement:

Corrective Action Log

#	Problem	Required Action	Who	By When	Done

Reviewed By (name/position) **Date**

19.0 HEPATITIS B VACCINATION FORM

SECTION A: SIGN UP FORM

Some people may have received the Hepatitis B Vaccine in grade school. If this is true for you, and given your role as a first aid attendant, we will still need to check your immunity status through bloodwork to ensure you have developed protective antibodies to Hepatitis B Virus as some people may not respond to the initial series or some may require a booster vaccine.

Birthdate (M/D/Y):	Gender (M/F):	Alberta Care Card No:
Email:	Home Address:	
Phone:	Job Title:	

Complete this section if you would like to receive the Hepatitis B Vaccination:

Country of Birth:	Date Moved to Canada (if applicable):
Did you complete your primary course of vaccinations in childhood? (These are vaccines usually given in infancy or early childhood.)	☐ YES ☐ NO ☐ UNSURE
Have you had a HEP B Vaccine in the past?	☐ YES ☐ NO ☐ UNSURE

Dates of Hepatitis B Vaccine (M/D/Y):

Dose 1: _____ Dose 2: _____ Dose 3: _____

☐ I am including a copy of my paper records
☐ I do not have paper records but have verbal confirmation of these dates

SECTION B: DECLINE PARTICIPATION

I have read the information above and understand that my assigned duties may involve a risk of exposure to Hepatitis B Virus through blood transmission. I understand that Western Canadian Construction is offering me Hepatitis B Vaccine at no cost as per Alberta OHS Regulations requirements and I am hereby **decline** receiving the Hepatitis B Vaccination:

☐ I decline receiving the Hepatitis B Vaccination.

Print Name:	Signature:	Date:	

20.0 EMPLOYEE WRITE UP FORM

Subcontractor/Employee Write Up

Employee Information

Employee Name: **Date:**

Company: **Job Title:**

Supervisor:

Type of Warning

☐ First Warning ☐ Second Warning ☐ Final Warning

Type of Offenses

☐ Tardiness/Leaving Early ☐ Absenteeism ☐ Violation of Company Policies

☐ Substandard Work ☐ Violation of Safety Rules ☐ Rudeness to Customers/Coworkers

☐ Other: _____

Details

Description of Infraction:

Plan for Improvement:

Consequences of Further Infractions:

Acknowledgment of Receipt of Warnings

By signing this form, you confirm that you understand the information in this warning. You also confirm that you and your manager have discussed the warning and a plan for improvement. Signing this form does not necessarily indicate that you agree with this warning.

Subcontractor/Employee Signature	Date
Site Safety Officer Signature	Date
Supervisor Signature	Date

21.0 EMPLOYEE INFORMATION

Name: _____

Address: _____

Phone Number: _____

Cell Number: _____

SIN: _____

Birth Date: _____

Driver's License: _____

Care Card Number: _____

Emergency Contact Information:

Name: _____

Telephone Number: _____

Cell Number: _____

Relation: _____

22.0 EXCAVATION SITE INSPECTION

(To be completed by a Competent Person)

SITE LOCATION:			
DATE:	TIME:	COMPETENT PERSON:	
SOIL CLASSIFICATION:	EXCAVATION DEPTH:	EXCAVATION WIDTH:	
TYPE OF PROTECTIVE SYSTEM USED:			

Indicate for each item: YES - NO - or N/A for not applicable

1. General Inspection of Jobsite:	
A. Excavations, adjacent areas, and protective systems inspected by a competent person daily before the start of work.	
B. Competent person has the authority to remove employees from the excavation immediately.	
C. Surface encumbrances removed or supported.	
D. Employees protected from loose rock or soil that could pose a hazard by falling or rolling into the excavation.	
E. Hard hats worn by all employees.	
F. Spoils, materials, and equipment set back at least two feet from the edge of the excavation.	
G. Barriers provided at all remotely located excavations, wells, pits, shafts, etc.	
H. Walkways and bridges over excavations four feet or more in depth are equipped with standard guardrails and toeboards.	
I. Warning vests or other highly visible clothing provided and worn by all employees exposed to public vehicular traffic.	
J. Employees required to stand away from vehicles being loaded or unloaded.	
K. Warning system established and utilized when mobile equipment is operating near the edge of the excavation.	
L. Employees prohibited from going under suspended loads.	
M. Employees prohibited from working on the faces of slopes or benched excavations above other employees.	
2. Utilities:	
A. Utility companies contacted and/or utilities located.	
B. Exact location of utilities marked.	
C. Underground installations protected, supported, or removed when excavation is open.	
3. Means of Access and Egress:	
A. Lateral travel to means of egress no greater than 25 feet in excavations four feet or more in depth.	
B. Ladders used in excavations secured and extended three feet above the edge of the trench.	
C. Structural ramps used by employees designed by a competent person.	
D. Structural ramps used for equipment designed by a registered professional engineer (RPE)	
E. Ramps constructed of materials of uniform thickness, cleated together on the bottom, equipped with no-slip surface.	
F. Employees protected from cave-ins when entering or exiting the excavation.	

4. Wet Conditions:	
A. Precautions taken to protect employees from the accumulation of water.	
B. Water removal equipment monitored by a competent person.	
C. Surface water or runoff diverted or controlled to prevent accumulation in the excavation.	
D. Inspections made after every rainstorm or other hazard-increasing occurrence.	
5. Hazardous Atmosphere and Confined Space:	
A. Atmosphere within the excavation tested where there is a reasonable possibility of an oxygen deficiency, combustible or other harmful contaminant exposing employees to a hazard.	
B. Adequate precautions taken to protect employees from exposure to an atmosphere containing less than 19.5% oxygen and/or to other hazardous atmospheres	

C. Ventilation provided to prevent employee exposure to an atmosphere containing flammable gas in excess of 10% of the lower explosive limit of the gas.	
D. Testing conducted before and during to ensure that the atmosphere remains safe.	
E. Emergency equipment, such as breathing apparatus, safety harness and lifeline, and/or basket stretcher readily available where hazardous atmospheres could or do exist.	
F. Employees trained to use personal protective and other rescue equipment.	
G. Safety harness and lifeline used and individually attended when entering	
H. Entry permit filled out and signed by supervisor	
I.Second person (top man) for rescue	
J. Harnesses and other rescue equipment in reliable shape	
6. Support Systems:	
A. Materials and/or equipment for support systems selected based on soil analysis, trench depth, and expected loads.	
B. Materials and equipment used for protective systems inspected and in good condition.	
C. Materials and equipment not in good condition have been removed from service.	
D. Damaged materials and equipment used for protective systems inspected by a registered professional engineer (RPE) after repairs and before being placed back into service.	
E. Protective systems installed without exposing employees to the hazards of cave-ins, collapses, or threat of being struck by materials or equipment.	
F. Members of support system securely fastened to prevent failure.	
G. Support systems provided in ensure stability of adjacent structures, buildings, roadways, sidewalks, walls, etc.	
H. Excavations below the level of the base or footing supported, approved by an RPE.	
I. Removal of support systems progresses from the bottom and members are released lowly as to note any indication of possible failure.	
J. Backfilling progresses with removal of support system.	
K. Excavation of material to a level no greater than two feet below the bottom of the support system and only if the system is designed to support the loads calculated for the full depth.	
L. Shield system placed to prevent lateral movement.	
M. Employees are prohibited from remaining in shield system during vertical movement.	
Jobsite General Continued	
7. Site Access	
A. Clean, level ground	
B. Adequate ramps	
8. Protective Equipment	
A. Hard hats worn	
B. Eye & Face Protection (available/worn?)	
C. Hearing protection (available/worn?)	
D. Respiratory Protection (available/worn?)	
9. Guardrails Barricades and Control Zones	
A. Located where required	
B. Properly constructed	
C. Secured properly	
10. Ladders	
A. Secured	
B. Proper angle (extension ladders)	
C. Proper size and type	
D. Safe usable condition	
E. Properly used	

11. Fire Protection	
A. Extinguishers where required/up to date	
B. Fully Charged	
C. Emergency plan	
12. Housekeeping	
A. Clear walkways	
B. Clear work areas	
C. Clean and tidy storage containers	
13. Power tools and Equipment	
A. General condition	
B. Proper guards, cords and PPE	
C. Tagging as DEFECTIVE	
14. Gas Cylinders	
A. Properly located	
B. Properly secured and stored	
15. First Aid Requirements	
A. Competent and certified first aid attendant on site	
B. First Aid kits available and labeled	
C. Emergency eye wash stations available and labeled	
D. Worker knowledge of First Aid attendant's contact information	
16. Machines and Equipment	
A. Pre Trip filled out and signed	
B. Competent and trained operator	
C. Safe setup of equipment	
D. Condition of slings and hardware	
E. Safety catches on all hooks	
F. Proper use of tag chains	
G. Tag chains affixed with certification tag and not expired	
17. Traffic Control	
A. Trained traffic controllers	
B. Properly located	
C. Proper PPE	
D. Proper signage in place	
18. Signs and Print Material	
A. OHSR and WCA available	
B. MSDSs for substances on site	
C. Warning signs	
D. Emergency phone list	
19. Materials Storage	
A. Properly located	
B. Safely piled, stacked, bundled	
C. Properly labeled (WHIMIS)	
20. Hygiene	
A. Cleanliness of facilities	

DATE:	SIGNATURE:

WEATHER:	PROJECT:
Was One Call System contacted: Yes _____ No _____	
Protective system: Trench shield (box) _____ Wood shoring _____ Sloping _____ Other _____	
Purpose of trenching: Drainage _____ Water _____ Sewer _____ Gas _____ Other _____	
Were visual soil tests made: Yes_____ No _____ If yes, what type?	
Type of Soil: Stable Rock _____ Type A _____ Type B _____ Type C _____	
Surface encumbrances: Yes _____ No _____ If yes, what type?	
Water conditions: Wet _____ Dry _____ Submerged _____	
Hazardous atmosphere exists: Yes _____ No _____ *(If yes, follow confined space entry procedures policy; complete confined Space Entry Permit; monitor for toxic gas(es))*	
Is trenching or excavation exposed to public vehicular traffic (exhaust emission): Yes _____ No _____ *(If yes, refer to confined space entry procedures; complete Confined Space Entry Permit; monitor for toxic gas(es))*	
Measurements of trench: Depth _____ Length _____ Width _____	
Is ladder within 25 feet of all workers: Yes _____ No _____	
Is excavated material stored two feet or more from edge of excavation: Yes _____ No_____	
Are employees exposed to public vehicular traffic: Yes _____ No_____ *(If yes, warning vests required)*	
Are other utilities protected: Yes _____ No _____ *(Water, sewer, gas or other structures)*	
Are sewer or natural gas lines exposed: Yes _____ No _____	
Periodic Inspection: Yes _____ No _____	
Did employees receive training in excavating: Yes _____ No _____	

Corrective Actions and Remarks:

DAILY TRENCHING LOG