

CLIMATE ENGINEERS

883 Shaver Rd. NE Cedar Rapids, IA

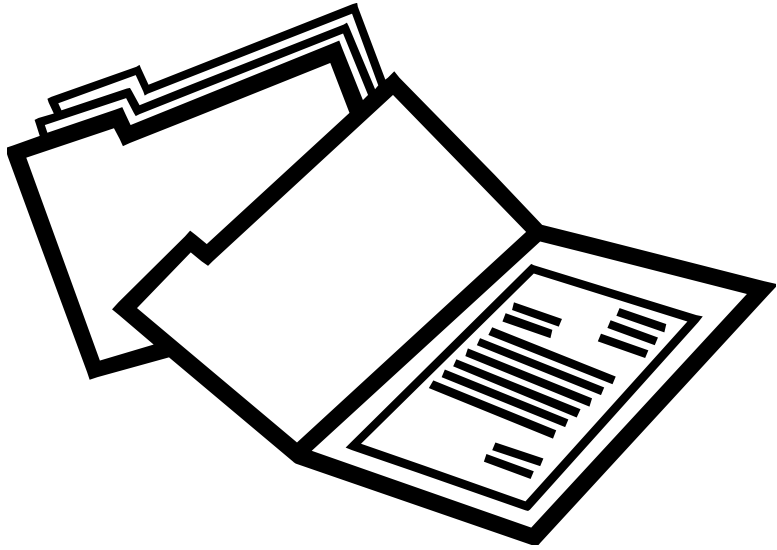
CLIMATE RIVER VALLEY

210 Fisher Ct. Eldridge, IA



**CLIMATE
ENGINEERS**

**INVESTIGATION
FORMS**



OUR GOAL IS **ZERO** INJURIES IN THE WORKPLACE



ACCIDENT INVESTIGATION FORM

Accident investigation forms/statements must be filled out by the injured employee, foreman or any witness to the accident. Please follow the instructions listed below to ensure that the investigation process will be performed accurately and efficiently.

1. Employee **immediately** reports accidents to Supervisor or Site Foreman.
2. **REPORT ALL INJURIES!!** If injury requires routine job site first aid, treat injury and then fill out accident investigation form. ALL injuries must be recorded. Anything considered %small+could lead to something %BIG+if not properly cared for.
3. If medical treatment is needed beyond regular first aid, supervisor/site foreman will drive or appoint an approved Climate Engineer or Climate River Valley employee to take the injured employee to an emergency care clinic/emergency room.

Climate Engineers: St. Luke's Hospital in Cedar Rapids is our emergency employer contact as well as St. Luke's Work Well Clinic. Severe or Life Threatening injuries will require a 911 call.

Climate River Valley: Genesis Occupational Health in Davenport or Moline is our emergency employer contact. Please use whichever one is closer to the accident location. Severe or Life Threatening injuries will require a 911 call.

4. If injury requires a trip to an emergency care clinic/emergency room, inform the clinic that Climate Engineers and Climate River Valley has a light duty/return to work program. Supervisor/Site Foreman must wait for the injured party to be treated or have a phone available to be reached to return to the clinic/emergency room to pick up the injured employee. **Under NO circumstances should an injured employee be allowed to drive themselves to the emergency care clinic or emergency room.**
5. After treatment, the injured employee **must fill out** the Employee's %Report of Injury+form. Supervisor must fill out the Supervisor's %Accident Investigation Form+and if there were any witnesses to the accident, they must fill out the %Accident Witness Statement+form. Once all forms are filled out, the forms need to be turned in to the Safety Director or Co-Safety Coordinator in Climate's office. **These forms need to be in the office within 24 hours of the accident (or fax forms if job site is out of town).**
6. **ALL calls to 911** needs to be documented and CRV Safety Director or Co-Safety Coordinator needs to be called within the hour of the accident/injury.

OUR GOAL IS **ZERO** INJURIES IN THE WORKPLACE



EMPLOYEE'S REPORT OF ACCIDENT/INCIDENT WITH INJURY

to be completed by employee

Employee's Name: _____ Male Female
Last First Middle Initial Circle One

Date of Birth: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____ SS#: _____

How long have you been employed at Climate Engineers: _____

Location of Accident: _____
Name and Address of Building &/or Site Area (bathroom etc)

Date of Accident: _____ Time of Accident: _____ AM or PM
Circle One

Describe Fully How the Accident Occurred: _____

Describe Bodily Injury Sustained (be Specific about body part(s) affected): _____

Recommendation of How to Prevent this Accident from Reoccurring (continue on reverse side if necessary):

Name of Supervisor/Site Foreman: _____
Last First Middle Initial

Name(s) of Any Witnesses: _____
ATTACH WITNESS(S) REPORT(S)

When did you Report the Accident to your Supervisor/Foreman? _____
Date Time

Did you Report the Accident to Office: Safety Coordinator or Co-Safety Coordinator _____
Yes No

Employee Name Printed Employee Signature Date of this Report

OUR GOAL IS ZERO INJURIES IN THE WORKPLACE



EMPLOYEE'S REPORT OF INCIDENT/NEAR MISS

NO INJURY

to be completed by employee

Employee's Name: _____ Male Female
Last First Middle Initial Circle One

Date of Birth: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____ SS# _____

How long have you been employed at Climate Engineers: _____

Location of Incident: _____
Name and Address of Building or Site Area (bathroom etc)

Date of Incident: _____ Time of Incident: _____ AM or PM
Circle One

Describe Fully how the Incident Occurred: _____

Describe Bodily Parts That Could Were Affected or Could Have Been Affected: _____

Recommendation of How to Prevent this Incident from Reoccurring (continue on reverse side if necessary):

Name of Supervisor/Site Foreman: _____
Last First Middle Initial

Name(s) of Any Witnesses: _____
ATTACH WITNESS(S) REPORT(S)

When did you Report the Incident to your Supervisor/Foreman? _____
Date Time

Did you Report the Incident to Office: Safety Coordinator or Co-Safety Coordinator _____
Yes No

Employee Name Printed Employee Signature Date of this Report

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ACCIDENT/INCIDENT/NEAR MISS WITNESS STATEMENT

to be completed by witness

Injured or Affected Employee's Name: _____
Last First Middle Initial

Name of Witness: _____ Job Title of Witness: _____
Last First Middle Initial

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

How long have you been employed at Climate Engineers: _____

Was this any Accident with Injury or An Incident or Near Miss: _____

Location of Accident/ Incident/Near Miss: _____
Name and Address of Building or Site Area (bathroom etc)

Date and Time of Accident/Incident/Near Miss: _____

Describe Fully how the Accident/Incident/Near Miss Occurred: _____

Describe Bodily Parts That Could Have Been or Were Affected by Accident/Incident/Near Miss:

Recommendation of How to Prevent this Accident/ Incident/Near Miss from Reoccurring
(continue on reverse side if necessary): _____

Name of Supervisor/Site Foreman: _____
Last First Middle Initial

When did you Report the Incident to your Supervisor/Foreman: _____
Date Time

Did you Report the Incident to Office: Safety Coordinator or Co-Safety Coordinator _____
Yes No

Witness Name Printed Witness Signature Date of this Report

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SUPERVISOR'S ACCIDENT/INCIDENT/NEAR MISS INVESTIGATION

to be completed by Supervisor or Other Responsible Administrative Official

Location where accident occurred:		Employer's Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No Job Site: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of accident or illness:
Name of injured person:		<input type="checkbox"/> Employee <input type="checkbox"/> Non-employee		Time of Accident <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Length of time with firm:	Job Title/ Occupation:	How long has employee worked at site where injury occurred:		
What property was damaged:			Property owned by:	
What was employee doing when injury/illness occurred? What machine or tool? What operation?				
How did injury/illness? List all objects and substances involved.				
Part of body affected:		Any prior physical conditions or defects? If so, what? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nature & Extent of injury/illness and property damaged (be specific):				

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Improper Instruction | <input type="checkbox"/> Failure to Lockout | <input type="checkbox"/> Unsafe Arrangement or Process |
| <input type="checkbox"/> Lack of Training or Skill | <input type="checkbox"/> Unsafe Position | <input type="checkbox"/> Poor Ventilation |
| <input type="checkbox"/> Operating without Authority | <input type="checkbox"/> Improper Dress | <input type="checkbox"/> Improper Guarding |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Improper Protective Equipment | <input type="checkbox"/> Improper Maintenance |
| <input type="checkbox"/> Physical or Mental Impairment | <input type="checkbox"/> Unsafe Equipment | <input type="checkbox"/> Inoperative Safety Device |
| <input type="checkbox"/> Failure to Secure | <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Other _____ |

Supervisor's corrective action to insure this type of accident does not occur:

Was employee retained in the appropriate use of Personal Protective Equipment/Proper Safety Procedures Yes No
 Was employee cautioned for failure to use Personal Protective Equipment/ Proper Safety Procedures? Yes No

Supervisor's Name (Printed)

Supervisor's Signature

Date

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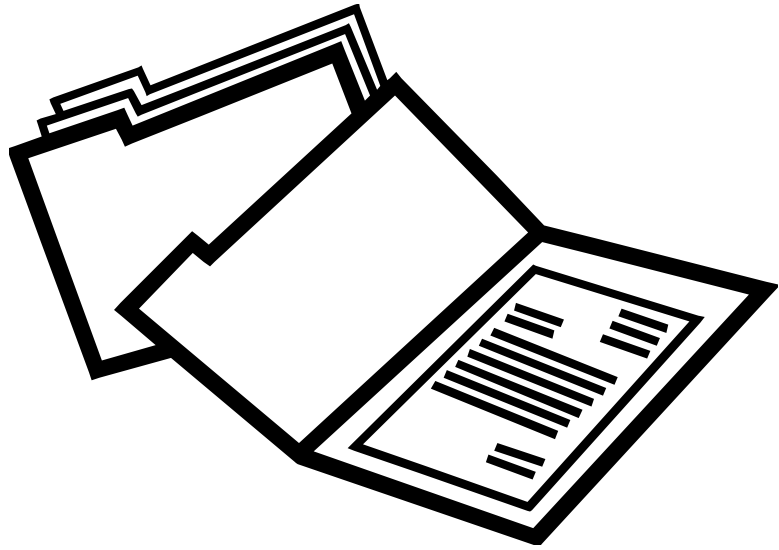
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6. **ALL calls to 911** needs to be documented and CRV Safety Director or Co-Safety Coordinator needs to be called within the hour of the accident/injury.

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EMPLOYEE'S REPORT OF ACCIDENT/INCIDENT WITH INJURY

to be completed by employee

Employee's Name: _____ **Male** **Female**
Last First Middle Initial Circle One

Date of Birth: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____ SS#: _____

How long have you been employed at Climate Engineers: _____

Location of Accident: _____
Name and Address of Building &/or Site Area (bathroom etc)

Date of Accident: _____ Time of Accident: _____ **AM or PM**
Circle One

Describe Fully How the Accident Occurred: _____

Describe Bodily Injury Sustained (be Specific about body part(s) affected): _____

Recommendation of How to Prevent this Accident from Reoccurring (continue on reverse side if necessary):

Name of Supervisor/Site Foreman: _____
Last First Middle Initial

Name(s) of Any Witnesses: _____
ATTACH WITNESS(S) REPORT(S)

When did you Report the Accident to your Supervisor/Foreman? _____
Date Time

Did you Report the Accident to Office: Safety Coordinator or Co-Safety Coordinator _____
Yes No

Employee Name Printed Employee Signature Date of this Report

OUR GOAL IS ZERO INJURIES IN THE WORKPLACE



EMPLOYEE'S REPORT OF INCIDENT/NEAR MISS

NO INJURY

to be completed by employee

Employee's Name: _____ **Male** **Female**
Last First Middle Initial Circle One

Date of Birth: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____ SS# _____

How long have you been employed at Climate Engineers: _____

Location of Incident: _____
Name and Address of Building or Site Area (bathroom etc)

Date of Incident: _____ Time of Incident: _____ **AM or PM**
Circle One

Describe Fully how the Incident Occurred: _____

Describe Bodily Parts That Could Were Affected or Could Have Been Affected: _____

Recommendation of How to Prevent this Incident from Reoccurring (continue on reverse side if necessary):

Name of Supervisor/Site Foreman: _____
Last First Middle Initial

Name(s) of Any Witnesses: _____
ATTACH WITNESS(S) REPORT(S)

When did you Report the Incident to your Supervisor/Foreman? _____
Date Time

Did you Report the Incident to Office: Safety Coordinator or Co-Safety Coordinator
Yes No

Employee Name Printed _____ Employee Signature _____ Date of this Report _____

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ACCIDENT/INCIDENT/NEAR MISS WITNESS STATEMENT

to be completed by witness

Injured or Affected Employee's Name: _____
Last First Middle Initial

Name of Witness: _____ Job Title of Witness: _____
Last First Middle Initial

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

How long have you been employed at Climate Engineers: _____

Was this any Accident with Injury or An Incident or Near Miss: _____

Location of Accident/ Incident/Near Miss: _____
Name and Address of Building or Site Area (bathroom etc)

Date and Time of Accident/Incident/Near Miss: _____

Describe Fully how the Accident/Incident/Near Miss Occurred: _____

Describe Bodily Parts That Could Have Been or Were Affected by Accident/Incident/Near Miss:

Recommendation of How to Prevent this Accident/ Incident/Near Miss from Reoccurring
(continue on reverse side if necessary): _____

Name of Supervisor/Site Foreman: _____
Last First Middle Initial

When did you Report the Incident to your Supervisor/Foreman: _____
Date Time

Did you Report the Incident to Office: Safety Coordinator or Co-Safety Coordinator _____
Yes No

Witness Name Printed Witness Signature Date of this Report

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SUPERVISOR'S ACCIDENT/INCIDENT/NEAR MISS INVESTIGATION

to be completed by Supervisor or Other Responsible Administrative Official

Location where accident occurred:		Employer's Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of accident or illness:	
		Job Site: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of injured person:		<input type="checkbox"/> Employee <input type="checkbox"/> Non-employee		Time of Accident <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
Length of time with firm:	Job Title/ Occupation:	How long has employee worked at site where injury occurred:			
What property was damaged:			Property owned by:		
What was employee doing when injury/illness occurred? What machine or tool? What operation?					
How did injury/illness? List all objects and substances involved.					
Part of body affected:		Any prior physical conditions or defects? If so, what? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Nature & Extent of injury/illness and property damaged (be specific):					

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Improper Instruction | <input type="checkbox"/> Failure to Lockout | <input type="checkbox"/> Unsafe Arrangement or Process |
| <input type="checkbox"/> Lack of Training or Skill | <input type="checkbox"/> Unsafe Position | <input type="checkbox"/> Poor Ventilation |
| <input type="checkbox"/> Operating without Authority | <input type="checkbox"/> Improper Dress | <input type="checkbox"/> Improper Guarding |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Improper Protective Equipment | <input type="checkbox"/> Improper Maintenance |
| <input type="checkbox"/> Physical or Mental Impairment | <input type="checkbox"/> Unsafe Equipment | <input type="checkbox"/> Inoperative Safety Device |
| <input type="checkbox"/> Failure to Secure | <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Other _____ |

Supervisor's corrective action to insure this type of accident does not occur:

Was employee retained in the appropriate use of Personal Protective Equipment/Proper Safety Procedures Yes No
 Was employee cautioned for failure to use Personal Protective Equipment/ Proper Safety Procedures? Yes No

Supervisor's Name (Printed)

Supervisor's Signature

Date

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