SAFETY TRAINING DOCUMENTS

This section is designated to hold all Company Safety Training Documents. Any paperwork related to Company Safety Training will be 3-ring hole-punched and stored in this section.

ATTACHMENTS

- New Employee Safety Orientation Form
- Daily Job Log
- OSHA 300 - Log of Work-Related Injuries and Illness (sample)
- OSHA 300A - Summary of Work-Related Injuries and Illness (sample)
- OSHA 301 - Injury and Illness Incident Report (sample)

New Employee Safety Orientation Form

Employee Name:			Date Hired:	Orientation Date:
Job Title:		Unit Name:		
Check One	☐ New Employee	☐ Transfer	☐ Rehire	☐ Part Time	☐ Temporary

Check items covered:

- ☐ Safety Program
  - ☐ Safety Committee, Safety Meetings, Names of Safety Committee Representatives
  - ☐ Safety Policies and Procedures
  - ☐ Hazard Notification Procedure
- ☐ Accident Reporting
  - ☐ Report All Accidents to Supervisor Immediately
- ☐ First Aid
  - ☐ Names of First Aid Trained Employees
  - ☐ Location of First Aid Kits
  - ☐ Location of Another Emergency Equipment
  - ☐ How to Summon Medical Aid
- ☐ Emergency Action Plan
  - ☐ What to Do in The Event of Fire, Earthquake, Chemical Spill and Other Emergencies
  - ☐ Building Evacuation Procedures
  - ☐ Location of Exits, Evacuation Routes, And Designated Evacuation Location
  - ☐ Location of Fire Alarm Pull Stations and Fire Extinguishers
  - ☐ How to Summon Emergency Aid
- ☐ Personal Work Habits
  - ☐ Proper Lifting Techniques
  - ☐ Office Ergonomics
  - ☐ Good Housekeeping
  - ☐ Avoiding Slips and Falls
  - ☐ Indoor Air Quality Policy
  - ☐ Smoking Policy
- ☐ Potential Hazards on The Job
  - ☐ Identification of Job Specific Hazards and How to Minimize Hazards
  - ☐ Assigned Personal Protective Equipment – Care, Use, Limitations
  - ☐ Understanding the Risks of All Hazardous Materials and the Location of SDS
- ☐ On the Job Training (List)
  - ☐ Equipment Specific Training
  - ☐ Task Training
  - ☐ Regulatory Training

Instructor's Name:	Signature:	Date:
Trainee's Name:	Signature:	Date:

Daily Job Log

Job Location	Day of Week ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S	Job #	Today's Date
Job Name	Weather Conditions	Site Conditions	Time

Crew Foreman/Supervisor	Company Competent Person(s)

Crew Members	Start	Finish	Total	Special Materials Needed

Crew Members	Start	Finish	Total	Expected Problems/Delays Today

Special Safety Training/Equipment Required
Special Safety Requests/Assignments (describe)
Work Performed Today

Change Orders Issued (describe)	Authorized By

Special Tools/Equipment Rented Today	Rented From	Rate/hour	Total Cost

Material Purchased	Cost	Special Planning Required for Tomorrow

Accidents/Incidents/Near Misses (described)
Other
Supervisor's Signature

OSHA's Form 300 (Rev 01/2004)

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20

U.S. Department of Labor
Occupational Safety and Health Administration

Form Approved OMB No.12180176

You must record information about every work-related death and about every work-related injury or illness that revives lass of consciousness, restricted work activity or lob transfer, days away from work or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1004.12. Feel free to use two lines fora single case if you need to. You must complete a kV* and Illness Incident Report Form 301) or equivalent form for each injury or illness recorded on this form. If you are not sure whether a case is recordable, call your local OSHA office for help

Established Name

City

State

Identify the Person			Describe the Case			Classify: CHECK ONLY ONE box for each case based on the most serious outcome for that case				Enter the number of days the injured or ill worker was		Check the Injury column or choose one type of illness					
						Death	Days away from Work	Job transfer or restriction	Other record able cases	Away from Work	On Job Transfer or Restriction	Injury	Skin Disorder	Respiratory Illness	Poisoning	Hearing Loss	Other
A Case No.	**B** Name	**C** Job Title	**D**	**E** Location	**F** Describe Injury/Illness	**G**	**H**	**I**	**J**	**K**	**L**	**M**-1	**M**-2	**M**-3	**M**-4	**M**-5	**M**-6
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Page Totals												M-1	M-2	M-3	M-4	M-5	M-6

Be sure to transfer these totals to the Summary Page (Form 300A) before you post it.

Public reporting of this collected information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collected information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact US Department of Labor, OSHA Office of Statistical Analysis. Room #3644,

OSHA's Form 300 (Rev 01/2004)

Summary of Work-Related Injuries and Illnesses

Year 20

U.S. Department of Labor

Number of Cases

	Total number of deaths	Total number of cases with days away from work,	
	Total number of other recordable cases	Total number of cases with job transfer/restriction	

Number of Days

	Total number of days away from work.	Total number of days of job transfer or restriction	

Injury and Illness Types

	Total number of:		
	Injuries	Skin disorders	
	Respiratory Conditions	Poisonings	
	Hearing Loss	All Other Illnesses	

All establishments covered by Part 1904 must complete this Summary Page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category, then write the totals below, making sure you have added the entries from every page of the Log. If you had no cases, write 0.

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

The public reporting burden for this collection of information is estimated to average 1/2 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: U.S. Department of Labor, OSHA Off ice of Statistical Analysis, Room N 3644, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do Not send the completed forms to this office.

Establishment Information

Your Establishment Name:

Street

City	State	ZIP

Industry Description (e.g. Manufacture of motor truck trailers)

Standard Industrial Classification (SIG) (e.g. 3715)

North American Industrial Classification (NAICS)

Employment Information

(If you do not have these figures, see the Worksheet on the back of this

Annual average number of employees:	Total employee hours worked last year:

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document, and to the best of my knowledge, is true, accurate, and complete.

Print:

Signature:

Title	Phone:	Date:

OSHA's Form 301

Injury and Illness Incident Reports

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20

U.S. Department of Labor

Occupational Safety and Health Administration

Information about the Case

Case Number from the Log:	Date of Injury or Illness:
Time Employee Began Work:	Time of Event: ☐ Check if time cannot be verified

What was the employee doing just before the incident occurred? Describe the activity; as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry,"

What happened? Tell us how the injury occurred.
Examples: "When ladder slipped 011 wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist aver time."

What was the injury or illness? Tell on the part of the body that was affected and how it was affected; be more specific than "hurt" "pain," or "sore".

What object or substance directly harmed the employee?
Examples: "concrete floor"; "chlorine"; "radial arm saw."
NOTE: If this question does not apply to the incident, leave it blank.

If the employee died when did death occur? Date of death:
__/__/__

Information about the Employee

Full Name:		
Street Address:		
City:	State:	ZIP:
Date of Birth:	Date Hired:	☐ Male ☐ Female

Information about Health-Care Provider

Name of Health-Care Provider:				
Facility Address:				
City		State:		ZIP:
Was employee treated in an emergency room?	☐	**Yes**	☐	Was employee hospitalized overnight as an in-patient?
	☐	**No**	☐	

The public reporting burden for this collection of information is estimated to average 1/2 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: U.S. Department of Labor, OSHA Off ice of Statistical Analysis, Room N 3644, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do Not send the completed forms to this office.

This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the Log of Work-Related Injuries and Illnesses and the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHAs recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by:	
Title:	
Phone:	Date: