



**OREGON MILITARY DEPARTMENT**  
JOINT FORCE HEADQUARTERS, OREGON NATIONAL GUARD  
1776 MILITIA WAY  
P.O. BOX 14350  
SALEM, OREGON 97309-5047

AGP

July 15, 2010

MEMORANDUM FOR RECORD

Subject: Safety Meeting for July, 2010

The Oregon Military Department Safety Committee met on 13 July 2010, at the Military Department in room 200. The meeting convened at 1:30 PM. The status of Member attendance was as follows:

Owen Pence	Region 6	Chairman	Present
Timothy Gilbert	AGI	Member	Present
Robin Webb	AGP	Safety Manager/Recorder	Present
Bryce Dohrman	AGC	Risk Manager	Absent
Bruce Vollstedt	AGI	Member	Present
Jeff Beck	AGI	Member	Present
Terri Kroeker	DS-Air	Member	Present
Mike Wiley	Region 4	Member	Present
John Unger	Region 5	Member	Present
Vacant	Region 7	Member	Vacant
Dan Hinkley	Region 8	Member	Present
Terry Sevey	RTI	Member	Present
David Stuckey	OEM	Member	Absent
Cherie Zastoupil	OEM	Alternate for OEM	Present

**1. Review of Minutes:** The first order of business was to review the Safety Meeting minutes from the June, 2010 meeting. A motion to approve the minutes was given by John Unger and a second by Jeff Beck.

**2. Review of Accident/Incident Reports for the Agency for June:** There was only one of the seven submitted to the committee that was for this committee's review. It was the report surrounding a sliced finger caused by a sharp metal ring around the door knob. Tim and Jeff both indicated after the meeting they will take a look at it. The remainder of incidents was left for members to review after the committee meeting.

Robin also gave a Workers Comp update indicating she has received 5 new claims between last Friday and Monday of this week.

**3. Hazard/Non Hazard Log Review:** No new issues have been added to either log.

**4. July Safety Topics:** This month's safety topics are Hazard Identification, "Are you contaminating your family" and Confined Space, Permit-required - An Overview. All the information was reviewed within the committee and posted on the Safety Bulletin

Board. Robin sent out a "Monthly Safety Topic" email to all OMD employees. This information will also be posted to the AGP Safety page website on a monthly basis.

Robin also indicated that a topic we may want to add is Vehicle Safety being with all the budget cuts we have more of our people driving back and forth to several armories. The committee agreed.

**5. CPR/AED/First Aid Training Reminder:** There is one AED/CPR/First Aid class scheduled at Camp Rilea on July 22<sup>nd</sup> at 10:00 AM and 1:00 PM. If anyone is interested in attending, please let Robin know.

**6. New Business:**

- a. Safety Training Update: Robin gave an update on the Safety Committee training that she and Marc Snook are doing. YCP, Camp Withycombe, PANG and K-Falls have all been completed. She and Marc are scheduled for Camp Rilea in September. This group will be the last group to be scheduled.
- b. Tool Box Talks now on the Safety Page website: Robin indicated that she has had Ralph add the Tool Box Talks to the website. Those Talks are a one page double sided document in which the front side talks about a safety topic and then the back page is a quiz.
- c. Health Fair Update: Next health fair is scheduled for October 6<sup>th</sup> at the Salem Auditorium. Hours are from 11:00 AM to 6:00 PM. Hopefully flu shots will be available if PEBB renews their contract. Looks like Salem Fire Dept. will be there, Marion County Health Dept. will have a couple of different sections attending. Also, working with Salem Hospital and their Community Mental Health program being involved. This would include some medical testing.
- d. Gas Leaks at Baker City Armory: Bruce indicated there has been several gas leaks in which employees were smelling gas. The gas company came out and identified two small leaks on a regulator last week. Today, the gas was very strong, the gas company was back and found a leaky regulator on top of the water heater. Gas was shut off and red tagged, Bruce is working on finding someone to either find a kit for the regulator or replace the regulator. Bruce indicated the employees in the building did the right thing. They contacted the gas company directly. A vendor will be there tomorrow to look at the regulators.

**11. Next Meeting:** The next meeting is scheduled for Tuesday at 1:30 PM, August 10, 2010 in the TAG Conference room, 200. The call in number is 1-866-700-9253 and the PIN is 2280321.

/s/  
Robin Webb  
Safety Manager & Recorder

AGENDA

JFHQ & Readiness Centers, Region 2 thru 8

Safety Committee Meeting

Location: JFHQ TAG Conf. Room 200

Date: Tuesday, July 13, 2010

Time: 1:30 PM

1. Review and approve June meeting minutes – All
2. Review of Accident/Incident Reports for June
3. Hazard Log Review/Non Hazard Log
4. July Safety Topics
5. Upcoming CPR Training Reminder – Scheduled July 22<sup>nd</sup>.
6. New Business:
  - a. Safety Training Update
  - b. Tool Box Talks now on Safety Page Website
  - c. Health Fair Update
  - d.
7. Next Meeting Date



REPORT OF INCIDENT/ACCIDENT/ILLNESS

WIC ✓

- PRINT OR TYPE (ART. 1) TO BE COMPLETED BY THE INCURRED EMPLOYEE OR ATTENDING STAFF
- IF A DOCTOR'S VISIT IS REQUIRED, COMPLETE SAIF 801 FORM IN ADDITION TO THIS FORM & FORWARD IMMEDIATELY
- FOLLOW THE GUIDELINES ON THE MEDICAL TRANSPORT CHECKLIST

1. NAME OF INDIVIDUAL: [REDACTED]		2. SECTION: 2100000	3. DATE OF REPORT: 7/16/2007
4. JOB TITLE: ES. SA. PAPER		5. TYPE OF INCIDENT/ACCIDENT/ILLNESS: NOT KNOWN	
6. EXTENT OF INJURY (body part or location of pain): [REDACTED]			
7. LOCATION WHERE INJURY OCCURRED: [REDACTED]			
8. DATE & TIME OF INCIDENT/ACCIDENT/ILLNESS: 7/12/2007 10:30 AM			
11. DATE REPORTED: 7/16/2007		12. REPORTED TO WHOM: [REDACTED]	
11. WITNESS (attach statement if necessary): RELATIONSHIP: SA. SUPERVISOR NAME: [REDACTED] PHONE: [REDACTED]		12. WITNESS (attach statement if necessary): RELATIONSHIP: SA. SUPERVISOR NAME: [REDACTED] PHONE: [REDACTED]	
14. DESCRIBE INCIDENT/ACCIDENT/ILLNESS FULLY (describe how it occurred, conditions when it occurred (weather, clothing, safety equipment, etc.) and describe how it felt to the individual when it occurred): I put the pallets on the shelf on customer in 4 days and the steel pipe fell on my head and hit me I felt very bad, that headache was started in sleep and had nausea			
15. DESCRIBE FIRST AID/MEDICAL TREATMENT: I applied ice on my head and took pill for pain relief (ibuprofen) Monday I visited my doctor			
16. WHERE WAS INDIVIDUAL SENT (IF TRANSPORTED):		17. MEANS OF TRANSPORTATION:	
18. INCURRED INDIVIDUAL'S WRITTEN COMMENTS: I am waiting on the results of CT scan I keep in contact with my doctor			

THIS SIDE TO BE COMPLETED BY SUPERVISOR

19. CONTRIBUTING FACTORS OF INCIDENT/ACCIDENT/ILLNESS:		
UNSAFE ACTIONS:		UNSAFE CONDITIONS:
<input type="checkbox"/> DISTRACTION, TEASING, HORSEPLAY <input type="checkbox"/> OPERATING WITHOUT AUTHORITY <input type="checkbox"/> MAKING SAFETY DEVICES IMOPERATIVE <input type="checkbox"/> TAKING UNSAFE POSITION <input type="checkbox"/> FAILURE TO USE PERSONAL PROTECTIVE DEVICES <input type="checkbox"/> OTHER:		<input type="checkbox"/> INADEQUATE SUPERVISION <input type="checkbox"/> DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE <input checked="" type="checkbox"/> HAZARDOUS ARRANGEMENT <input type="checkbox"/> SUB-STANDARD PHYSICAL CONDITIONING <input type="checkbox"/> UNSAFE CLOTHING <input type="checkbox"/> PREVIOUS INJURY <input type="checkbox"/> HAZARDOUS OBSTACLES <input type="checkbox"/> OTHER:
20. BACKGROUND: ARE THERE ANY CONTRIBUTING FACTORS, SUCH AS LEVEL OF TRAINING, PERSONAL CHARACTERISTICS, HABITS, FAILURE TO FOLLOW SAFETY POLICIES, ETC. THAT CAUSED THE INCIDENT/ACCIDENT/ILLNESS?		
NONE		
<b>GUIDES TO CORRECTIVE ACTION</b>		
21. IF AN UNSAFE ACTION AND/OR CONDITION WAS IDENTIFIED, LIST CORRECTIVE ACTION TAKEN:		
UNSECURE PIPE WAS REMOVED AND NO LONGER A SAFETY ISSUE		
22. ADDITIONAL SUPERVISOR COMMENTS:		
ALL CUSTOMER WERE DIRECTED TO BE AWARE OF SURROUNDINGS AS WELL AS EDGE OR CORNERS THAT COULD CAUSE INJURY		
23. SUPERVISOR NAME (PRINT):	24. SUPERVISOR SIGNATURE:	25. DATE:
[REDACTED]	[REDACTED]	16 JUN 2010
<b>SAFETY COMMITTEE REVIEW</b>		
26. SAFETY COMMITTEE RECOMMENDATIONS:		
APPROPRIATE ACTION HAVE BEEN TAKEN!		
27. SAFETY CHAIR SIGNATURE:	28. DATE:	
[REDACTED]	16 JUN 2010	

WC ✓

## REPORT OF INCIDENT/ACCIDENT/ILLNESS

- PRINT OR TYPE ONLY. TO BE COMPLETED BY THE INJURED EMPLOYEE OR ATTENDING STAFF  
 ➤ IF A DOCTOR'S VISIT IS REQUIRED, COMPLETE SAIF 801 FORM IN ADDITION TO THIS FORM & FORWARD IMMEDIATELY.  
 ➤ FOLLOW THE GUIDELINES ON THE MEDICAL TRANSPORT CHECKLIST

1. NAME OF INDIVIDUAL: [REDACTED]		2. Section: <i>Physical Security; Electronics</i>	3. DATE OF REPORT: 30 June 2010
4. JOB TITLE: <i>Office Specialist 2</i>		5. TYPE OF INCIDENT/ACCIDENT/ILLNESS: <i>Accident: fall</i>	
6. EXTENT OF INJURY (Body part or location of pain): <i>left arm, br arm, back, ankle, head</i>			
7. LOCATION WHERE INJURY OCCURRED: <i>10101 s.e. Clackamas rd Clackamas, OR 97015</i> <i>BLDG 6480 Security Control Room Electronics</i>			
8. DATE & TIME OF INCIDENT/ACCIDENT/ILLNESS: <i>30 June 2010 Approx: 1300</i>			
11. DATE REPORTED: <i>30 June 2010</i>		12. REPORTED TO WHOM: [REDACTED]	
13. WITNESS (attach statement if necessary) RELATIONSHIP: <i>CO-worker</i> SUPERVISOR, CO-WORKER, ETC. NAME: [REDACTED] PHONE: [REDACTED]		WITNESS (attach statement if necessary) RELATIONSHIP: <i>RSM Employee</i> SUPERVISOR, CO-WORKER, ETC. NAME: [REDACTED] PHONE: [REDACTED]	
14. DESCRIBE INCIDENT/ACCIDENT/ILLNESS FULLY (Include how it occurred, conditions when it occurred (weather, clothing, safety equipment, etc) and describe how it felt to the individual when it occurred): <i>standing on 3rd step of ladder getting devices from top shelf, when [REDACTED] came to the door needing assistance, [REDACTED] turned and stepped down missing/slipped from the first step. [REDACTED] was surprised after the fall. Requested no medical treatment, but will seek doctors advice when relieved from duty.</i>			
15. DESCRIBE FIRST AID/MEDICAL TREATMENT: <i>None at time of incident [REDACTED] left work at 1405 to seek medical treatment/checkup. 501 form sent with [REDACTED] for filing.</i>			
16. WHERE WAS INDIVIDUAL SENT (IF TRANSPORTED): <i>N/A</i>		17. MEANS OF TRANSPORTATION: <i>N/A</i>	
18. INJURED INDIVIDUALS WRITTEN COMMENTS: <i>On third-step of ladder when [REDACTED] came to the pickup door needing assistance. Turned and started down the ladder slipped/fell from 1st step. Fell on back side and left arm affecting back ankle and head.</i>			

**THIS SIDE TO BE COMPLETED BY SUPERVISOR**

19. CONTRIBUTING FACTORS OF INCIDENT/ACCIDENT/ILLNESS:

UNSAFE ACTIONS: *yes*

UNSAFE CONDITIONS:

- DISTRACTION, TEASING, HORSEPLAY
- OPERATING WITHOUT AUTHORITY
- MAKING SAFETY DEVICES INOPERATIVE
- TAKING UNSAFE POSITION
- FAILURE TO USE PERSONAL PROTECTIVE DEVICES
- OTHER:

- INADEQUATE SUPERVISION
- DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE
- HAZARDOUS ARRANGEMENT
- SUB-STANDARD PHYSICAL CONDITIONING
- UNSAFE CLOTHING
- PREVIOUS INJURY
- HAZARDOUS OBSTACLES
- OTHER:

*Came down the ladder at an angle, falling from 1st step*

20. BACKGROUND:

ARE THERE ANY CONTRIBUTING FACTORS, SUCH AS LEVEL OF TRAINING, PERSONAL CHARACTERISTICS, HABITS, FAILURE TO ADHERE TO SAFETY POLICIES, ETC. THAT CAUSED THE INCIDENT/ACCIDENT/ILLNESS?

*distraction by another employee may have a contributing factor to this incident*

**GUIDES TO CORRECTIVE ACTION**

21. IF AN UNSAFE ACTION AND/OR CONDITION WAS IDENTIFIED, LIST CORRECTIVE ACTION TAKEN:

*Will provide training to employee on the use of ladders. see attached training info*

22. ADDITIONAL SUPERVISOR COMMENTS:

*Suggest using a ceiling stair case instead of folding step ladder*

23. SUPERVISOR NAME (PRINT):

[Redacted Name]

24. SUPERVISOR SIGNATURE:

[Redacted Signature]

25. DATE:

*6-30-10*

**SAFETY COMMITTEE REVIEW**

26. SAFETY COMMITTEE RECOMMENDATIONS:

27. SAFETY CHAIR SIGNATURE:

28. DATE:

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30 June 2010

Approximately 1:15

I went to the security room to check in a unit for inspection. [redacted] was on a step ladder working with units stored on a high shelf at one of the movable storage bins. She began to climb down the ladder and was partially turned in my direction when her foot missed the last step and she fell toward the security room counter. She struck the floor with her left elbow and back. The ladder was arranged such that the steps faced the security room counter. After she fell I pushed the counter out of the way to assist her. She got up and told me that she had injured her elbow. I advised her to report the incident and asked if she was okay. I returned later and ~~she~~ she told me she made an incident report.

[redacted]



RSMS

CAMP WITHYCOMBE

CLACKAMAS, OREGON 97015

30 JUNE 2010

I [REDACTED] assisted in the investigation of the fall by [REDACTED] on 30 June 2010, in building 6480, security room.

She reported that she was on the 3<sup>rd</sup> step of the 4 step ladder, when [REDACTED] needed help at the counter for the security room. She turned her head and body to respond and went to get off the ladder at the same time. She either missed the last step or caught part of the step causing the ladder to tip over and fall with and on top of her.

She fell on her left side. She reported that her left wrist, arm side, and ankle hurt.

[REDACTED]



REPORT OF INCIDENT/ACCIDENT/ILLNESS

- > PRINT OR TYPE ONLY. TO BE COMPLETED BY THE INJURED EMPLOYEE OR ATTENDING STAFF
- > IF A DOCTOR'S VISIT IS REQUIRED, COMPLETE SAIF 801 FORM IN ADDITION TO THIS FORM & FORWARD IMMEDIATELY.
- > FOLLOW THE GUIDELINES ON THE MEDICAL TRANSPORT CHECKLIST

1. NAME OF INDIVIDUAL: [REDACTED]		2. Section: [REDACTED]	3. DATE OF REPORT: 28 June 2010
4. JOB TITLE: [REDACTED]		5. TYPE OF INCIDENT/ACCIDENT/ILLNESS: sliced fingers	
6. EXTENT OF INJURY (Body part or location of pain): cut			
7. LOCATION WHERE INJURY OCCURRED: little finger			
8. DATE & TIME OF INCIDENT/ACCIDENT/ILLNESS: 0800 on 28 June 2010			
11. DATE REPORTED: 28 June 2010		12. REPORTED TO WHOM: [REDACTED]	
13. WITNESS (attach statement if necessary): RELATIONSHIP: _____ SUPERVISOR, CO-WORKER, ETC. NAME: _____ PHONE: _____		WITNESS (attach statement if necessary): RELATIONSHIP: _____ SUPERVISOR, CO-WORKER, ETC. NAME: _____ PHONE: _____	
14. DESCRIBE INCIDENT/ACCIDENT/ILLNESS FULLY (include how it occurred, conditions when it occurred (weather, clothing, safety equipment, etc.) and describe how it felt to the individual when it occurred): while holding onto door knob & turning it to open door leading into TAB's coffee room when I turned the knob my finger got sliced from the metal ring put behind the door knob to cover hole. The edges of metal ring were not sanded smooth & are jagged.			
15. DESCRIBE FIRST AID/MEDICAL TREATMENT: band aid			
16. WHERE WAS INDIVIDUAL SENT (IF TRANSPORTED):		17. MEANS OF TRANSPORTATION:	
18. INJURED INDIVIDUAL'S WRITTEN COMMENTS: please fix the rough edges of metal			

**THIS SIDE TO BE COMPLETED BY SUPERVISOR**

19. CONTRIBUTING FACTORS OF INCIDENT/ACCIDENT/ILLNESS:		
UNSAFE ACTIONS:		UNSAFE CONDITIONS:
<input type="checkbox"/> DISTRACTION, TEASING, HORSEPLAY <input type="checkbox"/> OPERATING WITHOUT AUTHORITY <input type="checkbox"/> MAKING SAFETY DEVICES INOPERATIVE <input type="checkbox"/> TAKING UNSAFE POSITION <input type="checkbox"/> FAILURE TO USE PERSONAL PROTECTIVE DEVICES <input type="checkbox"/> OTHER: _____		<input type="checkbox"/> INADEQUATE SUPERVISION <input type="checkbox"/> DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE <input type="checkbox"/> HAZARDOUS ARRANGEMENT <input type="checkbox"/> SLB-STANDARD PHYSICAL CONDITIONING <input type="checkbox"/> UNSAFE CLOTHING <input type="checkbox"/> PREVIOUS INJURY <input type="checkbox"/> HAZARDOUS OBSTACLES <input checked="" type="checkbox"/> OTHER: <i>inappropriate suspecting of medal behind door knob</i>
<i>none</i>		
20. BACKGROUND: ARE THERE ANY CONTRIBUTING FACTORS, SUCH AS LEVEL OF TRAINING, PERSONAL CHARACTERISTICS, HABITS, FAILURE TO ADHERE TO SAFETY POLICIES, ETC. THAT CAUSED THE INCIDENT/ACCIDENT/ILLNESS?		
<i>No</i>		
<b>GUIDES TO CORRECTIVE ACTION</b>		
21. IF AN UNSAFE ACTION AND/OR CONDITION WAS IDENTIFIED, LIST CORRECTIVE ACTION TAKEN:		
<i>none yet - sent email to Troy Biadell/Tom Gilbert on 28 June 10</i>		
22. ADDITIONAL SUPERVISOR COMMENTS:		
23. SUPERVISOR NAME (PRINT):	24. SUPERVISOR SIGNATURE:	25. DATE:
<i>[Redacted]</i>	<i>[Redacted]</i>	<i>29 June 10</i>
<b>SAFETY COMMITTEE REVIEW</b>		
26. SAFETY COMMITTEE RECOMMENDATIONS:		
27. SAFETY CHAIR SIGNATURE:		28. DATE:

*WIK*

### REPORT OF INCIDENT/ACCIDENT/ILLNESS

- ▶ PRINT OR TYPE ONLY TO BE COMPLETED BY THE INJURED EMPLOYEE OR ATTENDING STAFF
- ▶ IF A DOCTOR'S VISIT IS REQUIRED, COMPLETE SAIF 801 FORM IN ADDITION TO THIS FORM & FORWARD IMMEDIATELY
- ▶ FOLLOW THE GUIDELINES ON THE MEDICAL TRANSPORT CHECKLIST

1. NAME OF INDIVIDUAL: [REDACTED]		2. CLASS/PLATOON: CA	3. DATE OF REPORT: 22 June 2010
4. JOB TITLE: CA		5. TYPE OF INCIDENT/ACCIDENT/ILLNESS: Insect stings	
6. EXTENT OF INJURY (Body part or location of pain): left elbow			
7. LOCATION WHERE INJURY OCCURRED: left elbow			
8. DATE & TIME OF INCIDENT/ACCIDENT/ILLNESS: 22 June 2010 1400			
11. DATE REPORTED: 22 June 2010		12. REPORTED TO WHOM: [REDACTED]	
13. WITNESS (attach statement if necessary) RELATIONSHIP: _____ SUPERVISOR, CO-WORKER, CADET ETC. NAME: _____ PHONE: _____		WITNESS (attach statement if necessary) RELATIONSHIP: _____ SUPERVISOR, CO-WORKER, CADET ETC. NAME: _____ PHONE: _____	
14. DESCRIBE INCIDENT/ACCIDENT/ILLNESS FULLY (Include how it occurred, condition when it occurred (weather, clothing, safety equipment, etc.) and describe how it felt to the individual when it occurred): Was on break and stung on the left elbow by an insect			
15. DESCRIBE FIRST AID/MEDICAL TREATMENT: TWO Anti-histamine			
NURSE WAS NOTIFIED (circle one): YES <input type="radio"/> NO <input checked="" type="radio"/>		16. WHERE WAS INDIVIDUAL SENT (IF TRANSPORTED): N/A	
17. MEANS OF TRANSPORTATION: N/A		18. INJURED INDIVIDUALS WRITTEN COMMENTS: Allergic reaction	

THIS SIDE TO BE COMPLETED BY SUPERVISOR

19. CONTRIBUTING FACTORS OF INCIDENT/ACCIDENT/ILLNESS:

UNSAFE ACTIONS: *V/A*

UNSAFE CONDITIONS: *V/+*

- DISTRACTION, TEASING, HORSEPLAY
- OPERATING WITHOUT AUTHORITY
- MAKING SAFETY DEVICES INOPERATIVE
- TAKING UNSAFE POSITION
- FAILURE TO USE PERSONAL PROTECTIVE DEVICES
- OTHER: \_\_\_\_\_

- INADEQUATE SUPERVISION
- DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE
- HAZARDOUS ARRANGEMENT
- SUB-STANDARD PHYSICAL CONDITIONING
- UNSAFE CLOTHING
- PREVIOUS INJURY
- HAZARDOUS OBSTACLES
- OTHER: \_\_\_\_\_

20. BACKGROUND:

ARE THERE ANY CONTRIBUTING FACTORS, SUCH AS LEVEL OF TRAINING, PERSONAL CHARACTERISTICS, HABITS, FAILURE TO ADHERE TO SAFETY POLICIES, ETC. THAT CAUSED THE INCIDENT/ACCIDENT/ILLNESS?

*NO*

21. IF AN UNSAFE ACTION AND/OR CONDITION WAS IDENTIFIED, LIST CORRECTIVE ACTION TAKEN:

*None*

22. ADDITIONAL SUPERVISOR COMMENTS:

*Staff was stung by a bee while on break at the end of the driveway.*

23. SUPERVISOR NAME (PRINT):

*[Redacted]*

24. SUPERVISOR SIGNATURE:

*[Redacted Signature]*

25. DATE:

*[Redacted Date]*

26. COMMANDANT'S COMMENTS:

27. COMMANDANT'S SIGNATURE:

28. DATE:

29. OYCP HEALTH CARE PROVIDER'S COMMENTS: CADET SEEN  NOT SEEN

30. HEALTH CARE PROVIDER'S SIGNATURE:

31. DATE:

32. SAFETY COMMITTEE RECOMMENDATIONS:

33. SAFETY CHAIR SIGNATURE:

34. DATE:

W/C ✓

### REPORT OF INCIDENT/ACCIDENT/ILLNESS

- > PRINT OR TYPE ONLY. TO BE COMPLETED BY THE INJURED EMPLOYEE OR ATTENDING STAFF
- > IF A DOCTOR'S VISIT IS REQUIRED, COMPLETE SAIF 801 FORM IN ADDITION TO THIS FORM & FORWARD IMMEDIATELY.

1. NAME OF INDIVIDUAL: [REDACTED]		2. Section:	3. DATE OF REPORT: 6-10-10
4. JOB TITLE: FACILITY ENERGY TECHNICIAN		5. TYPE OF INCIDENT/ACCIDENT/ILLNESS: CUT ON TOP OF HEAD	
6. EXTENT OF INJURY (Body part or location of pain): CUT ON TOP OF HEAD			
7. LOCATION WHERE INJURY OCCURRED: ON MEZZANINE IN EAST BAY OF HANGAR 219			
8. DATE & TIME OF INCIDENT/ACCIDENT/ILLNESS: 6-10-2010 2:30 PM			
11. DATE REPORTED: 6-10-2010		12. REPORTED TO WHOM: [REDACTED]	
13. WITNESS (attach statement if necessary) RELATIONSHIP: _____ SUPERVISOR, CO-WORKER, ETC. NAME: _____ PHONE: _____		WITNESS (attach statement if necessary) RELATIONSHIP: _____ SUPERVISOR, CO-WORKER, ETC. NAME: _____ PHONE: _____	
14. DESCRIBE INCIDENT/ACCIDENT/ILLNESS FULLY (include how it occurred, conditions when it occurred (weather, clothing, safety equipment, etc.) and describe how it felt to the individual when it occurred): RAN INTO PIPE HANGER BRACKET WHILE DUCKING DOWN TO WALK UNDER BEAMS, CONDUITS, PIPES, ETC. CAUSING 3.5 CM LACERATION ON TOP OF HEAD.			
15. DESCRIBE FIRST AID/MEDICAL TREATMENT: CLEANED WOUND AND STAPLE. SUTURED TOGETHER			
16. WHERE WAS INDIVIDUAL SENT (IF TRANSPORTED): DROVE SELF TO KLAMATH MEDICAL CLINIC		17. MEANS OF TRANSPORTATION: PERSONAL VEHICLE	
18. INJURED INDIVIDUAL'S WRITTEN COMMENTS:			

**THIS SIDE TO BE COMPLETED BY SUPERVISOR**

19. CONTRIBUTING FACTORS OF INCIDENT/ACCIDENT/ILLNESS:		
UNSAFE ACTIONS:		UNSAFE CONDITIONS:
<input type="checkbox"/> DISTRACTION, TEASING, HORSEPLAY <input type="checkbox"/> OPERATING WITHOUT AUTHORITY <input type="checkbox"/> MAKING SAFETY DEVICES INOPERATIVE <input type="checkbox"/> TAKING UNSAFE POSITION <input type="checkbox"/> FAILURE TO USE PERSONAL PROTECTIVE DEVICES <input type="checkbox"/> OTHER: _____		<input type="checkbox"/> INADEQUATE SUPERVISION <input type="checkbox"/> DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE <input type="checkbox"/> HAZARDOUS ARRANGEMENT <input type="checkbox"/> SUB-STANDARD PHYSICAL CONDITIONING <input type="checkbox"/> UNSAFE CLOTHING <input type="checkbox"/> PREVIOUS INJURY <input checked="" type="checkbox"/> HAZARDOUS OBSTACLES <input type="checkbox"/> OTHER: _____
20. BACKGROUND: ARE THERE ANY CONTRIBUTING FACTORS, SUCH AS LEVEL OF TRAINING, PERSONAL CHARACTERISTICS, HABITS, FAILURE TO ADHERE TO SAFETY POLICIES, ETC. THAT CAUSED THE INCIDENT/ACCIDENT/ILLNESS? <i>There is a newly install fire sprinkler system on the mezzanine in building 219. We have HC Units to service these and have to duct down to get under pipes</i>		
<b>GUIDES TO CORRECTIVE ACTION</b>		
21. IF AN UNSAFE ACTION AND/OR CONDITION WAS IDENTIFIED, LIST CORRECTIVE ACTION TAKEN: <i>We are taking a look at it to see if we can cap the hangers OR make it a hard hat area OR both</i>		
22. ADDITIONAL SUPERVISOR COMMENTS: _____ _____		
23. SUPERVISOR NAME (PRINT): <i>[Redacted]</i>	24. SUPERVISOR SIGNATURE: <i>[Redacted]</i>	25. DATE: <i>4/15/10</i>
<b>SAFETY COMMITTEE REVIEW</b>		
26. SAFETY COMMITTEE RECOMMENDATIONS: _____ _____		
27. SAFETY CHAIR SIGNATURE:	28. DATE:	

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REPORT OF INCIDENT/ACCIDENT/ILLNESS

- PRINT OR TYPE ONLY. TO BE COMPLETED BY THE INJURED EMPLOYEE OR ATTENDING STAFF
- IF A DOCTOR'S VISIT IS REQUIRED, COMPLETE SAJP 801 FORM IN ADDITION TO THIS FORM & FORWARD IMMEDIATELY.
- FOLLOW THE GUIDELINES ON THE MEDICAL TRANSPORT CHECKLIST

1. NAME OF INDIVIDUAL: [REDACTED]		2. Section: Fire Dept	3. DATE OF REPORT: 6/23/10
4. JOB TITLE: Captain		5. TYPE OF INCIDENT/ACCIDENT/ILLNESS: Hand Injury	
6. EXTENT OF INJURY (Body part or location of pain): Left hand pain/			
7. LOCATION WHERE INJURY OCCURRED: Flightline Alpha row on F-15			
8. DATE & TIME OF INCIDENT/ACCIDENT/ILLNESS: 6/22/10 Left hand pain			
11. DATE REPORTED: 6/23/10 @ 1055		12. REPORTED TO WHOM: [REDACTED]	
13. WITNESS (attach statement if necessary) RELATIONSHIP: Co Worker SUPERVISOR, CO-WORKER, ETC NAME: [REDACTED] PHONE: [REDACTED]		WITNESS (attach statement if necessary) RELATIONSHIP: Co Workers SUPERVISOR, CO-WORKER, ETC NAME: [REDACTED] PHONE: [REDACTED]	
14. DESCRIBE INCIDENT/ACCIDENT/ILLNESS FULLY (include how it occurred, conditions when it occurred (weather, clothing, safety equipment, etc), and describe how it felt to the individual when it occurred): Was training on F-15 aircraft. Climbing ladder to assist co worker into pilot seat. When climbing up felt a pop in left hand between wrist and first knuckles. It's on top of hand. Having sharp pain and having hard time grabbing objects with pain. Did not have much pain at first, but having more pain second day after onset.			
15. DESCRIBE FIRST AID/MEDICAL TREATMENT: NONE AT TIME OF INCIDENT			
16. WHERE WAS INDIVIDUAL SENT (IF TRANSPORTED):		17. MEANS OF TRANSPORTATION:	
18. INJURED INDIVIDUAL'S WRITTEN COMMENTS: SAME AS #14			

**THIS SIDE TO BE COMPLETED BY SUPERVISOR**

19. CONTRIBUTING FACTORS OF INCIDENT/ACCIDENT/ILLNESS:		
UNSAFE ACTIONS:		UNSAFE CONDITIONS:
<input type="checkbox"/> DISTRACTION, TEASING, HORSEPLAY <input type="checkbox"/> OPERATING WITHOUT AUTHORITY <input type="checkbox"/> MAKING SAFETY DEVICES INOPERATIVE <input type="checkbox"/> TAKING UNSAFE POSITION <input type="checkbox"/> FAILURE TO USE PERSONAL PROTECTIVE DEVICES <input type="checkbox"/> OTHER: _____		<input type="checkbox"/> INADEQUATE SUPERVISION <input type="checkbox"/> DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE <input type="checkbox"/> HAZARDOUS ARRANGEMENT <input type="checkbox"/> SUB-STANDARD PHYSICAL CONDITIONING <input type="checkbox"/> UNSAFE CLOTHING <input type="checkbox"/> PREVIOUS INJURY <input type="checkbox"/> HAZARDOUS OBSTACLES <input type="checkbox"/> OTHER: _____
20. BACKGROUND: ARE THERE ANY CONTRIBUTING FACTORS, SUCH AS LEVEL OF TRAINING, PERSONAL CHARACTERISTICS, HABITS, FAILURE TO ADHERE TO SAFETY POLICIES, ETC. THAT CAUSED THE INCIDENT/ACCIDENT/ILLNESS? <u>NONE NOTED DURING INTERVIEW</u>		
<b>GUIDES TO CORRECTIVE ACTION</b>		
21. IF AN UNSAFE ACTION AND/OR CONDITION WAS IDENTIFIED, LIST CORRECTIVE ACTION TAKEN: <u>NONE NOTED DURING INTERVIEW</u>		
22. ADDITIONAL SUPERVISOR COMMENTS: <u>Capt. [redacted] sustained this injury yesterday 22 JUNE 10, Reported it to me today 23 JUNE 10, explanation of PAID @ hand today but had no pain after injury.</u>		
23. SUPERVISOR NAME (PRINT): <u>[redacted]</u>	24. SUPERVISOR SIGNATURE: <u>[redacted]</u>	25. DATE: <u>23 JUNE 10</u>
<b>SAFETY COMMITTEE REVIEW</b>		
26. SAFETY COMMITTEE RECOMMENDATIONS: _____ _____		
27. SAFETY CHAIR SIGNATURE:	28. DATE:	







## HAZARD IDENTIFICATION

### ● ● A Chemical's Label Tells You

- **WHAT** It Is
- **WHY** It Can Be Dangerous

#### ● To find out the *Kind* of hazard, look for:

➤ **WORDS:** Flammable, Explosive, Carcinogen, Irritant

➤ **PICTURE SYMBOLS:**



➤ **COLORS:**

Red: Fire hazard

Blue: Health hazard

Yellow: Reactivity hazard

White: Specific hazard or Personal Protective Equipment

#### ● To find out the *Degree* of hazard, look for:

➤ **SIGNAL WORDS:**

**DANGER:** Risk of immediate serious injury or death

**WARNING:** Risk of serious injury or death

**CAUTION:** Risk of moderate injury

➤ **NUMBERS:**

**0:** Minimum hazard

**1:** Slight hazard

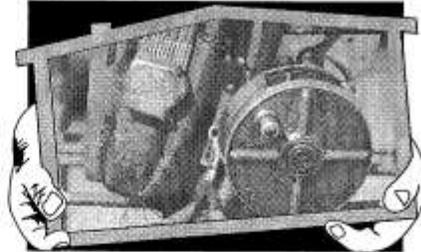
**2:** Moderate hazard

**3:** Serious hazard

**4:** Severe hazard

## ARE YOU CONTAMINATING YOUR FAMILY?

### Don't Take Your Work Home With You



#### **Take-home toxins can be transported home:**

- On work clothes and shoes
- On tools and equipment
- On other items taken home from the workplace
- On your body, including skin and hair

#### **To prevent exposure to hazardous substances at work:**

- Change into clean work clothes as soon as you arrive at work.  
—Store your street clothes in a clean area.
- Use good safety practices to reduce exposure.  
—Wear all required PPE.  
—Wash hands thoroughly with soap and water often.
- Assume clothing and PPE have become contaminated.  
—Place contaminated work clothes and PPE in assigned containers.
- Shower before putting on clean street clothes.  
—If showers are not available, wash up at work and shower as soon as you get home.
- Do not allow family members to visit the work area.
- *Never skip these steps—make them a habit.*

#### **To prevent exposure to hazardous substances at home:**

- Never Take-Home any equipment, tools, scrap, or packaging that has been exposed to toxic materials.
- Never wear contaminated work clothes home. Wash contaminated clothes and PPE at work, not at home.
- If you suspect that a hazardous material could be affecting your child, consult with your physician and have the child tested.

## Confined Space, Permit-required—An Overview

### Overview

A permit-required confined space is a confined space that has one or more of the following characteristics:

- contains or has the potential to contain a hazardous atmosphere;
- contains a material that has the potential for engulfing an entrant;
- has an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging walls or by a floor which slopes downward and tapers to a smaller cross-section; or
- contains any other recognized serious safety or health hazard.

### The Confined Space Program

Your employer has a permit-required confined space program which is designed to prevent accidents. Each permit-required confined space is marked with signs or other warnings.



### What must I do?

Before entering into a permit space, you must obtain an entry permit from the entry supervisor. The entry supervisor will determine if acceptable entry conditions are present.

Before entering into a permit-required confined space you must also:

- have been trained by your employer, and informed of the potential hazards that exist in the permit space, and be aware of the mode, signs and symptoms, and consequences of being exposed.
- know what personal protective equipment is needed, and how to properly use it.
- know how to summon rescue and emergency services.
- and understand the duties of the attendant and how to communicate with the attendant.