FACILITY RISK ASSESSMENT

Name(s) of Risk Team Members:	Point Value → Parameter ↓	1	2	3	4	5
Area/Facility Description Title: Area/Facility # (if applicable):	Occupancy Or Use	≤once/year	≤once/month	≤once/week	≤once/day	≤once/shift
Area/Facility Description:	Severity	First Aid Only	Medical Treatment	Lost Time	Partial Disability	Death or Permanent Disability
Training and Procedures List: Approved by: Date: Draft Rev. #	Likelihood	Very Unlikely	Unlikely	Possible	Probable	Multiple

		Before Controls						After Initial Controls						After Additional Controls					
	Hazard (s)	Occupancy A	Severity B	Likelihood C	Legal Exposure E	Risk* (AxBxC)+E	Initial Controls	Occupancy A	Severity B	Likelihood C	Legal Exposure E	Risk* (AxBxC)+E	Control(s) Added to Reduce Risk	Occupancy A	Severity B	Likelihood C	Legal Exposure E	Risk* (AxBxC)+E	% Risk Reduction

Further Description of Controls Added to Reduce Risk:

*Risk	0 to20	21 to40	41 to60	61 to80	81 or greater
	Negligible	Acceptable	Moderate	Substantial	Intolerable

Note: For legal exposure, the value should be either 5 for identified legal requirements or 0 for no such requirements could be identified.

Reviewed by (MR):

Approved by (MD):

JOB RISK ASSESSMENT

Name(s) of Risk Team Members:	Point Value → Parameter ↓	1	2	3	4	5
Job Title: Job Number or Job Identifier:	Frequency (B)	≤once/year	≤once/month	≤once/week	≤once/day	≤once/shift
Job Description:	Severity (C)	First Aid Only	Medical Treatment	Lost Time	Partial Disability	Death or Permanent Disability
Training and Procedures List: Approved by: Date: Rev. #	Likelihood (D)	Extremely Unlikely	Unlikely	Possible	Possible	Multiple
Stressors (if applicable, please list all):	Reason for Revision (if applicable):			Comments:		

			Before Additional Controls								After Additional Controls							
Job Step/Task	Hazard	Control(s)	Stressors Y/N	# of People A	Frequency B	Severity C	Likelihood D	Legal Exposure E	Risk* (AxBxCxD)+E	Control(s) Added to Reduce Risk	Stressors Y/N	# of People A	Frequency B	Severity C	Likelihood D	Legal Exposure E	Risk* (AxBxCxD)+E	% Risk Reduction

Further Description of Controls Added to Reduce Risk:

*Risk	0 to20	21 to40	41 to60	61 to80	81 or greater
	Negligible	Acceptable	Moderate	Substantial	Intolerable

Each hazard should occupy one line in the risk table. That is, the risk from each hazard is to be assessed individually. A single activity like "welding, soldering or brazing" must be entered three times in the table since there are three hazards associated with this activity, which are UV exposure, burns and fires.

Note: For legal exposure, the value should be either 5 for identified legal requirements or 0 for no such requirements could be identified.

Reviewed by (MR): Approved by (MD):

RISK CONTROL ACTION PLAN

Location:

TITLE:

OBJECTIVE:

Adopted at Management meeting held on:

Action	Action by	Start date	Completion date	Date completed

Progress/revision dates (see over)				

Reviewed by (MR):

Approved by (MD):

Mr. .....
Designation:
Department/Section:

Sub: Request for Annual JRA Review

You are requested to review the JRA assessment (SF-OHS-02) for job ..... made on dated .....

For your action, following members will assist you in the process of review.

1.
2.
3.
4.

You are requested to submit the report on review (to be made as per form no. SF-OHS-02) by .....

_____
Management Representative
Date:

Copy to:

1.
2.
3.
4.

ANNUAL JRA REVIEW REPORT

Following items were checked from previous Job Risk Assessment (JRA) (SF-OHS-02) made on .....

1.
2.
3.
4.
5.

Following modifications were suggested after reviewing the previous JRA done on .....

	Job Step/Task	Hazard	Control(s)	Before Recommendations for Controls						Recommendation for Control(s) to be Added to Reduce Risk	Reasons for Recommendations
				Stressors Y/N	# of People A	Frequency B	Severity C	Likelihood D	Risk* AxBxCxD		

Recommendations made by:

1. ..... Date:
2. ..... Date:
3. ..... Date:
4. ..... Date:
5. ..... Date:

Reviewed by:

_____
Management Representative
Date:

Approved by:

_____
Managing Director
Date:

REGISTER OF LEGISLATION

Sl. No.	Document No.	Title	Published by	Date of Issue	Revision No.	Entered on	Initial

Management Representative
Date:

COMPLIANCE OF LEGAL REQUIREMENTS

SL. NO.	Legal Reference	Requirements	Method of compliance	Responsibility	Evidence of Compliance	Remarks

Management Representative
Date:

Reviewed by (MR):

Approved by (MD):

ASSESSMENT OF WORKING CONDITION

Date of Assessment: **Assessor:**

Site Location:

Sl. #	Area	Temperature (^{0}C)	Light (Lx)	Noise Level (db)	Humidity (db)	Safety Status	Signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							

Signature:
Date:

Reviewed by (MR): Approved by (MD):

GENERAL INSPECTION REPORT

Date_____

Location/Department _____

Yes = Satisfactory
No = Unsatisfactory, needs attention

Yes	No	Safe Work Practices	Yes	No	Fire Protection
		Use of machine guards			Fire extinguishers
		Proper manual lifting			Proper type/location
		Smoking only in safe, designated areas			Storage of flammable materials
		Proper use of air hoses			Other_____
		No horseplay			**Tools and Machinery**
		Other_____			Lawn mowers
		Use of Personal Protective Equipment			Power tools
		Eye/face protection			Hand tools
		Footwear			Machine guarding
		Gloves			Belts, pulleys, gears, shafts
		Protective clothing			Oiling, cleaning, adjusting
		Head protection			Maintenance, oil leakage
		Aprons			Other_____
		Respirators			**First aid**
		Other_____			First aid kits in rooms/vehicles
		Housekeeping			Trained first aid providers
		Proper storage areas			Emergency numbers posted
		Proper storage of flammable material (oily/greasy rags, etc.)			All injuries reported
		Proper disposal of waste			Other _____
		Floors (clean, dry, uncluttered)			**Miscellaneous**
		Maintenance of yards, parking lots			MSDS/Labels
		Other_____			Dust/vapour/fume control
		Electrical Safety			Safe use of ladders/scaffolds
		Machines grounding/GFI			New processes or procedures carried out
		Electrical cords			Other_____
		Electrical outlets			
		Other_____			

Notes

_____

_____

_____

Reported by:

1. ..... Date:
2. ..... Date:
3. ..... Date:

When completing the inspection report, it is required to classify each hazard (identified as Unsatisfactory) by degree of possible consequences (for example: A = major, B = serious, C = minor). In this way, priorities for remedial action are established. If a hazard that poses an immediate threat is discovered, preventive action must be taken right away, not after the inspection.

Reviewed by (MR):

Approved by (MD):

WORKPLACE INSPECTION REPORT

INSPECTORS:	DATE:		
	(O)Satisfactory (X) Requires Action		
	Location	**Condition**	**Comments**
TRAINING			
Is training provided for each person newly assigned to a job?			
Does initial training include a thorough review of hazards and accidents associated with the job?			
Is adequate instruction in the use of personal protective equipment provided?			
Is training for the use of emergency equipment provided?			
ENVIRONMENT			
Are resources available to deal with very hot or very cold conditions (drinking water, lined gloves, insulated boots)?			
Are work surfaces and grip surfaces safe when wet?			
Do workers know the symptoms of heat cramps, heatstroke?			
WORK PROCESS			
Do joint committee members have access to material safety data sheets?			
Are workers informed (by hazard signs and tags)?			
Have all trucks, forklifts and other equipment been inspected and maintained?			
Is ventilation equipment working effectively?			
FIRE EMERGENCY PROCEDURES			
Is there a clear fire response plan posted for each work area?			
Do all workers know the plan?			
Are drills held regularly?			
Are fire extinguishers chosen for the type of fire most likely in that area?			
Are there enough extinguishers present to do the job?			
Are extinguisher locations conspicuously marked?			
Are extinguishers properly mounted and easily accessible?			
Are all extinguishers fully charged and operable?			
Are special purpose extinguishers clearly marked?			
MEANS OF EXIT			
Are there enough exits to allow prompt escape?			
Do employees have easy access to exits?			
Are exits unlocked to allow egress?			
Are exits clearly marked?			
Are exits and exit routes equipped with emergency lighting?			
WAREHOUSE AND SHIPPING			
Are dock platforms, bumpers, stairs and steps in good condition?			
Are light fixtures in good condition?			
Are all work areas clean and free of debris?			
Are stored materials properly stacked and spaced?			
Are tools kept in their proper place?			
Are there metal containers for oily rags and for rubbish?			
Are floors free of oil spillage or leakage?			
Is absorbent available for immediate clean-up of spills and leaks?			
Are all flammable and combustible products stored appropriately?			

Reviewed by (MR):

Approved by (MD):

	Location	Condition	Comments
LOADING/UNLOADING RACKS			
LIGHTING			
MACHINE GUARDS			
Are all dangerous machine parts adequately guarded?			
ELECTRICAL			
Are all machines properly grounded?			
Are portable hand tools grounded or double insulated?			
Are junction boxes closed?			
Are extension cords out of the aisles where they can be abused by heavy traffic?			
Are extension cords being used as permanent wiring?			
TOOLS AND MACHINERY			
Are manufacturers' manuals kept for all tools and machinery?			
Do power tools conform to standards?			
Are tools properly designed for use by employees?			
Are defective tools tagged and removed from service as part of a regular maintenance program?			
Are tools and machinery used so as to avoid electrical hazards?			
Is proper training given in the safe use of tools and machinery?			
CONFINED SPACES			
Are entry and exit procedures available and adequate?			
Are emergency and rescue procedures in place (e.g. trained safety watchers)?			
HOUSEKEEPING			
Is the work area clean and orderly?			
Are floors free from protruding nails, splinters, holes and loose boards?			
Are aisles and passageways kept clear of obstructions?			
Are covers or guardrails in place around open pits, tanks and ditches?			
FLOOR AND WALL OPENINGS			
Are ladder-ways and door openings guarded by a railing?			
ELEVATING DEVICES			
Are elevating devices used only within capacity?			
Are capacities posted on equipment?			
Are they regularly inspected, tested and maintained?			
Are operators trained?			
SOUND LEVEL/NOISE			
Are regular noise surveys conducted?			
Is hearing protection available?			
EMPLOYEE FACILITIES			
Are facilities kept clean and sanitary?			
Are facilities in good repair?			
Are cafeteria facilities provided away from toxic chemicals?			
MEDICAL AND FIRST AID			
Is there a hospital or clinic nearby?			
Are there employees trained as first-aid practitioners on each shift worked?			
Are physician-approved first-aid supplies available?			
Are first-aid supplies replenished as they are used?			

	Location	Condition	Comments
PERSONAL PROTECTIVE EQUIPMENT			
Is required equipment provided, maintained and used?			
Does equipment meet requirements?			
Is it reliable?			
Is personal protection utilized only when it is not reasonably practicable to eliminate or control the hazardous substance or process?			
Are warning signs prominently displayed in all hazard areas?			
MATERIALS HANDLING AND STORAGE			
Is there safe clearance for all equipment through aisles and doors?			
Is stored material stable and secure?			
Are storage areas free from tipping hazards?			
Are only trained operators allowed to operate forklifts?			
Are specifications posted for maximum loads which are approved for shelving, floors and roofs?			
Are racks and platforms loaded only within the limits of their capacity?			
Are chain hoists, ropes and slings adequate for the loads and marked accordingly?			
Are sling inspected daily before use?			
Are all new, repaired, or reconditioned alloy steel chain slings proof-tested before use?			
Do personnel use proper lifting techniques?			
Is the size and condition of containers hazardous to workers?			
Are elevators, hoists, conveyors, balers, etc., properly used with appropriate signals and directional warning signs?			
Analysis and comments:			

Reported by:

1. ..... Date:
2. ..... Date:
3. ..... Date:

Reviewed by:

_____

Designation:
Date:

Action to be taken:

Assigned to:
To be completed by:

_____

Designation:
Date:

Action reviewed by:

_____

Designation:
Date:

Reviewed by (MR):

Approved by (MD):

OFFICES INSPECTION REPORT

INSPECTORS:	DATE:		
	(O) Satisfactory, (X) Requires Action		
	Location	Condition	Comments
BULLETIN BOARDS AND SIGNS			
Are they clean and readable?			
Is the material changed frequently?			
FLOORS			
Is there loose material, debris, worn carpeting?			
Are the floors slippery, oily or wet?			
STAIRWAYS AND AISLES			
Are they clear and unblocked?			
Are stairways well lighted?			
EQUIPMENT			
Are guards, screens and sound-dampening devices in place and effective?			
Is the furniture safe?			
- worn or badly designed chairs			
- sharp edges on desks and cabinets			
- poor ergonomics (keyboard elevation, chair adjustment)			
- crowding			
EMERGENCY EQUIPMENT			
Is all fire control equipment regularly tested?			
Is fire control equipment appropriate for the type of fire it must control?			
Is emergency lighting in place and regularly tested?			
BUILDING			
Do buildings conform to standards with respect to use, occupancy, building services, and plumbing facilities?			
Are the following structures built to ensure safety?			
- floor and wall openings			
- ladders, stairways and ramps			
- guardrails			
Are materials stored safely?			
SANITATION			
Are washrooms and food preparation areas clean?			
Are the following provided adequately?			
- toilets			
- showers			
- potable water			
- clothing storage			
- change rooms			
- field accommodations			
- lunchrooms			
SECURITY			
Do entry and exit procedures provide workers personal security at night?			
Are emergency (evacuation, fire, bomb threat) procedures in place?			
LIGHTING			
Are lamp reflectors clean?			
Are bulbs missing?			
Are any areas dark?			

Reviewed by (MR):

Approved by (MD):

	Location	Condition	Comments
MATERIAL STORAGE			
Are materials neatly and safely piled?			
Are passageways and work areas clear of obstructions?			
GENERAL			
Are electrical or telephone cords exposed in areas where employees walk?			
Are machines properly guarded?			
Is electrical wiring properly concealed?			
Does any equipment have sharp metal projections?			
Are wall and ceiling fixtures fastened securely?			
Are paper and waste properly disposed of?			
Are desk and file drawers kept closed when not in use?			
Are office accessories in secure places?			
Are materials stacked on desks or cabinets?			
Are file cabinet drawers overloaded?			
Analysis and comments:			

Reported by:

1. ..... Date:
2. ..... Date:
3. ..... Date:

Reviewed by:

_____

Designation:
Date:

Action to be taken:

Assigned to:
To be completed by:

_____

Designation:
Date:

Action reviewed by:

_____

Designation:
Date:

TOOL BOX TALK

Date:	Attendees Name & signature
Location:	1. 2. 3. 4. 5. 6. 7.
Talk Given by: Designation:	
To Whom:	
Language in which Briefing given:	
Talk About (Topics/ Activities in Berief)	
Required PPE:	
Special Safety instructions:	
Discussion in brief:	
Sub-Divisional / Assistant Engineer: (Sub-Station In –Charge)	Signature :

LIGHTING CHECKLIST

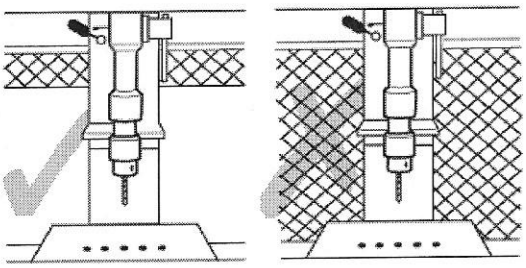
Location_____

Department/Areas covered _____

Date of Inspection _____

Time of Inspection _____

_____

General	
Enough light for the task.	
No troublesome reflections.	
No glare along or near normal line of sight	
No frequent transitions between extremes of light and dark or near and far.	
Lamps covered to diffuse light evenly.	
Adequate lighting of upper walls and ceilings.	
Shadows eliminated.	
Bright shiny objects out of view.	
Office	
Clear and readable images on VDT.	
Well-placed local lighting.	
VDTs positioned parallel to windows.	
VDTs positioned parallel to fluorescent light fixtures.	
Matte finishes on furniture and equipment.	
Blinds or curtains on windows.	
Brightness and contrast controls properly adjusted on VDTs.	
Appropriate size print, and good contrast on reading materials.	
Industry	
Very small objects magnified in addition to good lighting.	
Moving machinery parts painted a colour which contrasts with the background.	
Adequate lighting in storage rooms, stairways and hallways.	
Simple background behind tasks.	
	
Maintenance	
Regular replacement of bulbs.	
Regular cleaning of light fixtures.	
Upper walls and ceilings clean.	

Reported by:

1. ..... Date:
2. ..... Date:
3. ..... Date:

Reviewed by (MR):

Approved by (MD):

Reviewed by:

_____
Designation:
Date:

Action to be taken:

Assigned to:
To be completed by:

Approved by:

_____
Designation:
Date:

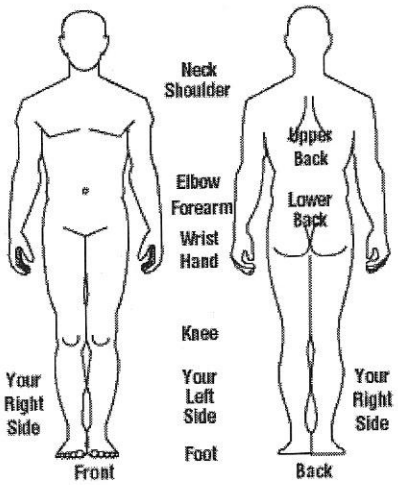
Action reviewed:

_____
Designation:
Date:

Use the checklist and answer yes or no to the following questions. Follow up any "no" answers with corrective action. A complete lighting survey may be necessary.

MEDICAL HISTORY CHECKLIST

1. Current job title? _____
2. What is your sex? ❑ Male ❑ Female
3. How long have you been employed at your present job? _____
4. In this diagram the body parts are shown approximately. Please indicate where your pain or discomfort is located, if any. Shade in any area(s) where you have had pain or discomfort that lasted 2 days or more in the last year which was caused by your job. If you did not shade in any area, go to question #46.



5. In the last year, have you had pain or discomfort caused by your job that lasted 2 days or more?

a) Neck	❑ Yes	❑ No
b) Shoulder	❑ Yes	❑ No
c) Elbow	❑ Yes	❑ No
d) Wrist/forearm	❑ Yes	❑ No
e) Hand	❑ Yes	❑ No
f) Upper back	❑ Yes	❑ No
g) Lower back	❑ Yes	❑ No
h) Foot	❑ Yes	❑ No

If you answered "no" to all of these questions, go to question #46. If you answered "yes" to any of the points in a-h above, please answer the following questions for that particular part(s) of the body.

Neck pain

6. While working is the pain or discomfort:
   ❑ Less ❑ Same ❑ Worse
7. After your shift, is the pain or discomfort:
   ❑ Less ❑ Same ❑ Worse
8. After a week away from work, is the pain or discomfort:
   ❑ Less ❑ Same ❑ Worse
9. Has the pain or discomfort caused you to take time off work in the past year?
   ❑ Yes ❑ No
   If yes, how many days off in all? _____ days
10. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does it interfere with your work?
       ❑ No Interference
       ❑ Some Interference
       ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
       ❑ No Interference
       ❑ Some Interference
       ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
       ❑ No Interference
       ❑ Some Interference
       ❑ It affects me every night

Shoulder pain

11. While working is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
12. After your shift, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
13. After a week away from work, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
14. Has the pain or discomfort caused you to take time off work in the past year?
    ❑ Yes ❑ No
    If yes, how many days off in all? _____ days
15. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does it interfere with your work?
       ❑ No Interference
       ❑ Some Interference
       ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
       ❑ No Interference
       ❑ Some Interference
       ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
       ❑ No Interference
       ❑ Some Interference
       ❑ It affects me every night

Elbow pain

16. While working is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
17. After your shift, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
18. After a week away from work, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
19. Has the pain or discomfort caused you to take time off work in the past year?
    ❑ Yes ❑ No
    If yes, how many days off in all? _____ days
20. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does if interfere with your work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
    ❑ No Interference
    ❑ Some Interference
    ❑ It affects me every night

Wrist/forearm pain

21. While working is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
22. After your shift, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
23. After a week away from work, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
24. Has the pain or discomfort caused you to take time off work in the past year?
    ❑ Yes ❑ No
    If yes, how many days off in all? _____ days
25. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does if interfere with your work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
    ❑ No Interference
    ❑ Some Interference
    ❑ It affects me every night

Hand pain

26. While working is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
27. After your shift, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
28. After a week away from work, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
29. Has the pain or discomfort caused you to take time off work in the past year?
    ❑ Yes ❑ No
    If yes, how many days off in all? _____ days
30. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does if interfere with your work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
    ❑ No Interference
    ❑ Some Interference
    ❑ It affects me every night

Upper back pain

31. While working is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
32. After your shift, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
33. After a week away from work, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
34. Has the pain or discomfort caused you to take time off work in the past year?
    ❑ Yes ❑ No
    If yes, how many days off in all? _____ days
35. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does if interfere with your work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
    ❑ No Interference
    ❑ Some Interference
    ❑ It affects me every night

Lower back pain

36. While working is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
37. After your shift, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
38. After a week away from work, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
39. Has the pain or discomfort caused you to take time off work in the past year?
    ❑ Yes ❑ No
    If yes, how many days off in all? _____ days
40. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does if interfere with your work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
    ❑ No Interference
    ❑ Some Interference
    ❑ It affects me every night

Foot pain

41. While working is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
42. After your shift, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
43. After a week away from work, is the pain or discomfort:
    ❑ Less ❑ Same ❑ Worse
44. Has the pain or discomfort caused you to take time off work in the past year?
    ❑ Yes ❑ No
    If yes, how many days off in all? _____ days
45. To what degree has your pain or discomfort interfered with your work, your life outside of work, and your sleep in the past year?
    1) How much does if interfere with your work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to take time off work, how many days off in the past year? _____
    2) How much does it interfere with your life outside of work?
    ❑ No Interference
    ❑ Some Interference
    ❑ Had to take time off work due to pain
    If you had to stop activity, how many days in the past year did you stop it? _____
    3) How much does it interfere with your sleep?
    ❑ No Interference
    ❑ Some Interference
    ❑ It affects me every night

46. Do you experience any other health problems related to your work?

❑ Yes ❑ No

If yes, please describe

Advice: Signature: Date:

ACCIDENT REPORT

ACCIDENT/INCIDENT DATA

INCIDENT TYPE: ☐ With Presence ☐ Without Presence		☐ Without Damage	☐ With Damage
DATE:	TIME:	WORKED HOUR:	UNIT/PROJECT NAME/NO:
CLIENT:	PROJECT DESCRIPTION:		ACCIDENT/INCIDENT PLACE:
COMPANY: POWER GRID COMPANY OF BANGLADESH ☐ IF SUBCONTRACTOR (Company Name):			
EMPLOYEE NAME:	ID NUMBER :	NID NUMBER:	AGE:
HOME ADDRESS:	LOCATION:	DISTRICT:	TELEPHONE NO IF ANY:
JOB PATTERN:	PROFESSIONAL CATEGORY:	SENIORITY IN THE COMPANY (Month/Year):	SENIORITY WITH THIS JOB (Month/Year):
TYPE OF INJURY:	INJURED BODY PART:	REGULAR JOB? ☐ YES ☐ NO	

DESCRIPTION

CLEARLY DESCRIBE HOW THE ACCIDENT/INCIDENT OCCURRED:
EYEWITNESS STATEMENTS : (SIGNED/NOT SIGNED)
TREATMENT PROVIDED:
TEMPORARY/PERMANENT DISABLEMENT THAT COMPENSATABLE ACCORDING TO BANGLADESH LABOR LAW-2006:

ANALYSIS

IMMEDIATE CAUSES What Acts, Failures in the Act and / or Conditions Mainly to This Incident?
BASIC CAUSES, What are the Reasons for the Existence of These Acts and / or Conditions?

POTENTIAL SEVERITY OF THE INCIDENT/ACCIDENT			POSSIBILITY OF REPEAT			The Risk Was Included in The Risk Assessment?	
☐ VERY SERIOUS	☐ SERIOUS	☐ MINOR	☐ FREQUENT	☐ OCCASIONAL	☐ RARE	☐ YES	☐ NO

Reviewed by (MR):

Approved by (MD):

ACCIDENT REPORT

PREVENTION	
	ACTIONS TAKEN IMMEDIATELY:
	ACTIONS TAKEN/RECOMMENDED TO AVOID REPETITION OF THE INCIDENT/ACCIDENT:

INVESTIGATED BY:	DATE:	REVIEWED BY MANAGER (HSE):	DATE:

PHOTOGRAPHIC & ATTACHMENT APPENDIX

MONITORING AND CLOSING:	SIGN:	DATE:

Reviewed by (MR):

Approved by (MD):

To

Sir,

I hereby give notice under section of the Factories Act, 1965 of a dangerous occurrence in the factory as detailed below:

1. Date and hour of dangerous occurrence:

2. Full account of dangerous occurrence:

3. Name of persons who saw dangerous occurrence and can give important evidence:

4. Name of Location: _____ Substation, PGCB
   Address:

_____ Manager

Date

Note: When there occurs in the factory a dangerous occurrence, the Plant Manager shall report the occurrence within five hours:

(a) The Chief Inspector
(b) The Deputy Commissioner
(c) Inspector
(d) The Commissioner for Workmen's Compensation appointed under Workmen's Compensation Act
(e) In the case of fatal accident only, the Officer-in-Charge of police station (within the limits of which the factory is located
(f) Reports shall be sent by special messenger in the above form.

EXTERNAL COMMUNICATION RECORD

Date	Received From	Subject	Necessity of Reply	Findings on the Subject	Action Required	Responsibility	Action Completed on	Action Communicated on	Remarks

Reviewed by (MR):

Approved by (MD):

EXTERNAL COMPLAIN LOG

Date	Complained by (name, address, tel)	Received by	Complain in details	Day & time of incident	Root cause of the incident	Corrective Action	Decision taken By	Action taken on

Reviewed by (MR):

Approved by (MD):

LOG OF WORK-RELATED INJURIES AND ILLNESSES

Identify the person		Describe the case					Classify the case											
(A)	(B)	(C)	(D)		(E)	(F)	**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:					
Case No.	Employee's Name	Job Title (e.g., Welder)	Type of accident * (put the identity in number as shown below	Date of injury or onset of illness (mo./ day)	Where the event occurred (e.g. Loading dock north end)	Describe injury or illness, parts of body affected, and object/ substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch)	Death	Days away from work	Remained at work		Away From Work (days)	On job transfer or restriction (days)	Injury	Skin Disorder	Respiratory Condition	Poisoning	Hearing Loss	All other illnesses
									Job transfer or restriction	Other record- able cases								
							(G)	(H)	(I)	(J)	(K)	(L)	1	2	3	4	5	6

* 1= High voltage, 2= Hot Burning, 3= Gas Exposure, 4=Moving parts, 5=Hot surface, 6=Cut, 7=Chemical, 8=Slip/fall/trip, 9=Electricity, 10=Others

Reviewed by (MR):

Approved by (MD):

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
0	0	0	0
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
0	0
(K)	(L)

Injury and Illness Types

Total number of...			
(M)			
(1) Injury	0	(4) Poisoning	0
(2) Skin Disorder	0	(5) Hearing Loss	0
(3) Respiratory Condition	0	(6) All Other Illnesses	0

Post this Summary page from January 15 to January 21 of the year following the year

Reviewed by (MR):

Approved by (MD):

Establishment information

Name of establishment _____

Street _____

City _____ Zip _____ District _____

Industry description (e.g., Manufacture of .....)

_____

Standard Industrial Classification (SIC), if known

_____ _____ __ __

Employment information

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here
Date

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

_____ _____
General Management, Office Management Date

_____
Phone

INVESTIGATION REPORT ON ACCIDENT/INCIDENT

External contact (if relevant):	Date:	Report no.:
Department/site:	Raised by:	
Description of accident/incident	Type of accident*:	
Short term action taken: Action taken by:	Date:	
Proposed long term preventive action: Proposed by:	Date:	
Action to be taken:	Action to be taken by: Date by:	
	Action taken: Date:	

Record to be sent to DMR (OHS)/HR when completed

Verified as effective:	Date

* Explanation of use of numbering
* 1= High voltage, 2= Hot Burning, 3= Gas Exposure, 4=Moving parts, 5=Hot surface, 6=Cut, 7=Chemical, 8=Slip/fall/trip, 9=Electricity, 10=Others

Reviewed by (MR):

Approved by (MD):

MONTHLY SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

For the month: , 20...

Total Number of Cases

Sl. No.	Location	TYPE OF ACCIDENTS *									
	Section/Location	1	2	3	4	5	6	7	8	9	10
TOTAL FOR THE MONTH											

Prepared by **Date**

Approved by **Date**

Post this Summary page by 10th of the following month.

* Explanation of numbering
* 1= High voltage, 2= Hot Burning, 3= Gas Exposure, 4=Moving parts, 5=Hot surface, 6=Cut, 7=Chemical, 8=Slip/fall/trip, 9=Electricity, 10=Others

Reviewed by (MR):

Approved by (MD):

ANNUAL SUMMARY OF TYPE OF ACCIDENTS

For the year: 20…

Total Number of Cases

Sl. No.	Location	TYPE OF ACCIDENTS *									
	Section/Location	1	2	3	4	5	6	7	8	9	10
TOTAL FOR THE YEAR											

Prepared by **Date**

Approved by **Date**

Post this Summary page by January 15 to January 21 of the following the year.

* Explanation of numbering

* 1= High voltage, 2= Hot Burning, 3= Gas Exposure, 4=Moving parts, 5=Hot surface, 6=Cut, 7=Chemical, 8=Slip/fall/trip, 9=Electricity, 10=Others

BOMB THREAT FORM

Threatening Caller Profile

Date: _____ Time of call _____a.m./p.m.
Your name: _____
Caller's Exact Words: _____
_____
Male _____ Female_____
Try to estimate the following while speaking to the caller:
Adult _____ Teen _____ Child _____ Approx. Age. _____
Circle any and all characteristics that apply to the caller:

Voice:
Loud
Highly pitched
Raspy
Soft
Deep
Pleasant
Monotone

Speech:
Fast
Distinct
Stutter
Slurred
Slow
Distorted
Nasal

Accent:
Local
Foreign
Race
Region

Word Choice:
Very educated
Average
Poor
Foul
Other

Manner:
Calm
Rational
Coherent
Deliberate
Righteous
Angry
Irrational
Incoherent
Laughing
Crying

Background Noise:
Talking
Laughing
Music
Machinery
Typing
Traffic
Trains
Planes
Boats
Restaurant/Bar
Party
Quiet

Building Knowledge:
Very familiar
Some familiarity
No familiarity

Note:

Instructions:
- ✓ Be calm and courteous
- ✓ Let the caller speak
- ✓ Keep the caller on the line as long as you can
- ✓ Record as much of the caller's conversation verbatim, as possible. You are requested not to hang up on the caller under any circumstances
- ✓ Notify your supervisor / Manager immediately after the call.
- ✓ Don't tell anyone else about the call or caller.

Ask:

- ✓ Who are you?
- ✓ Where are you?
- ✓ What do you want from us?
- ✓ What kind of bomb is it?
- ✓ What does it look like? Please describe it
- ✓ Where is it located? Can you give us the location?
- ✓ What will cause it to detonate?
- ✓ What are you going to do?
- ✓ Many innocent people will be hurt. Why are you doing this?

Reviewed by (MR): Approved by (MD):

MONITORING AND MEASUREMENT OF OHS PERFORMANCE

Period: **to**

Sl.	Items	Requirements	Achievements	% of Achievements	Remarks
1	Objectives				
2	Action taken against identified high risks				
3	Outcome of the results of workplace safety inspections				
4	Compliance with applicable legislation and regulatory requirements				
5	Incidents of injuries and ill health				
6	Completion of legally required and other inspections as scheduled				
7	The extent to which programme(s) for reducing identified risks have been implemented				
8	Effectiveness of the employee participation process				
9	Implementation of health screening				
10	Occurrences and rates of incidents				
11	Occurrences and rates of ill health				
12	Lost time due to incident				
13	Lost time due to ill health				
14	Any actions following receipt of comments from interested parties				
15	Number of instances of non-compliance				
16	Average time for resolving nonconformities				
17	Percentage of employees completing OHS training				

Monitored by:
Comment:

_____
Designation:
Date:

Checked by:
Comment:

_____
Designation:
Date:

Reviewed by (MR):

Approved by (MD):

EVALUATION OF COMPLIANCE TO LEGAL AND OTHER REQUIREMENTS

Period: **to**

Sl.	Items	Requirements	Achievements	% of Achievements	Remarks
1	No. of actions taken against identified high risks				
2	No. of noncompliances found in the results of workplace safety inspections				
3	Compliance with applicable legislation and regulatory requirements				
4	No. of incidents of reported incidence				
5	Analysis of of test results from monitoring and testing				
6					
7	Effectiveness of the employee participation process				
8	Implementation of health screening				
9	Percentage of employees completing OHS training				

Compiled by:
Comment:

_____
Designation:
Date:

Checked by:
Comment:

_____
Designation:
Date:

Reviewed by (MR):

Approved by (MD):