The Trades Group, Inc. **I**n **C**ase of **E**mergency Package

This package includes The Trades Group, Inc.'s forms for different emergencies that workers might encounter while working on a project. The package is intended to give the employee the proper forms to be filled out **I**n **C**ase of **E**mergency (**ICE**).

All forms are to be completed by the injured worker, witnesses, foremen and/or a member of the Safety Department. These forms are required to be sent into the Safety Department by the end of the current workday of the injury or accident. (See fax and e-mail address of your areas below).

The Trades Group, Inc. Safety Department needs to be contacted in every instance that a form needs to be filled out.

At no time should any injury, accident, or near miss go unreported to the Safety Department beyond the day of occurrence. If so, a delay of treatment can take place and this could cause further implications in the recovery of the injured worker. If the injury to a worker is not reported or the paperwork is not filled out or turned in, the injury might be denied coverage by The Trades Group, Inc.'s insurance carrier. It is very important that all pertinent paperwork get turn in as soon as possible.

Forms included in the ICE Package:

1. **Incident Investigation Report**

This form is to be used when reporting any injury to an Employee.

2. **Property Damage Investigation Report**

This form is used to report all property damage, equipment, and personnel damage.

3. **Auto Accident Report**

This form is to be used when reporting a vehicle accident involving any company owned vehicles.

Southern California - 1-866-998-2750
E-mail – your area safety manager

Northern California - 1-866-998-2750
E-mail – your area safety manager

The TRADESGROUP
CONSTRUCTION & DEVELOPMENT

Type of Incident:
- ☐ First Aid
- ☐ Recordable
- ☐ Lost Time
- ☐ Property

(Office Use Only)

This Incident Report is to be filled out for ALL types of incidents involving personnel and equipment.
***Incident must be reported to direct supervisor and the Safety Department within 4 hours and investigation must be completed and submitted within 24 hours.**

EMPLOYEE INFORMATION:

Employee Name:_____ Birthdate: _____

Job Title:_____

Home Address:_____ Sex: M ☐ / F ☐ Date of Hire: _____

City/State/Zip Code:_____ Years in Occupation: _____

Contact Number: _____

PROJECT INFORMATION:

Job Name:_____ Job #: _____

Job Address:_____ Time on job site: _____

Exact location of incident (Bldg/Level/Area): _____

Supervisor's Name:_____ Project Manager: _____

INJURY/ILLNESS INFORMATION:

Date of Incident:_____ Time of Incident:_____ am/pm Date Reported: _____

Body Part Affected:_____ Nature of Injury:_____ Time Reported:_____ am/pm

Description of Incident:

_____

_____

MEDICAL FACILITY: NAME: _____

Treating Facility Address:_____ Phone #: _____

City/State/Zip Code:_____ Taken by whom? _____

Drug test performed? Yes No N/A

EQUIPMENT INFORMATION:

Was equipment involved in the incident? ☐ Yes ☐ No If yes, please provide the following information:

Type of Equipment:		**Serial Number:**	
Model:		**Owner of Equipment:**	

Is a certification required to operate equipment? ☐ Yes (Provide a copy of certification) ☐ No

Note: In the event of a serious accident/incident, **NOTHING** shall be removed from the scene of the accident/incident until the investigation is completed.

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EmployeeStatement

Employee Name: _____ Job Number: _____

Title: _____ Date of Incident: _____

Job Name: _____ Time of Incident: _____

1. Where were you when the incident occurred? _____

2. Describe what happened. Include what activity you were performing at the time of the incident.

3. Name of witnesses and/or other employees working with injured worker:

Name	Email or Phone Number	Company

4. What Personal Protective Equipment (PPE) were you wearing at the time of the incident? _____

5. What do you think could have been done to prevent this type of incident from occurring? _____

6. Were you offered medical treatment? ☐ Yes ☐ No ☐ N/A ☐ Refused Treatment

Employee's Signature: _____ **Date:** _____

Note: In the event of a serious accident/incident, **NOTHING** shall be removed from the scene of the accident/incident until the investigation is completed.

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INCIDENT INVESTIGATION REPORT

Witness Statement

Witness Name: _____ Job Number: _____

Title: _____ Job Name: _____

Home Address: _____ Date of Incident: _____

Phone #: _____ Time of Incident: _____

Employer Name: _____

Employer Phone #: _____

1. Where were you when the incident occurred? _____
2. What activity were you performing at the time of the incident? _____
3. What activity was the injured employee performing? _____

WITNESS Statement:

_____

_____

_____

_____

_____

_____

Signed by witness: _____ **Date:** _____

Note: In the event of a serious accident/incident, **NOTHING** shall be removed from the scene of the accident/incident until the investigation is completed.

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PROPERTY DAMAGE INVESTIGATION REPORT

Type of Incident:
☐ Property
☐ Equipment
☐ Personnel
(Office Use Only)

This Property Damage Investigation Report is to be filled out for **ALL** types of incidents including, but not limited to, property, personnel, and equipment.
***Incident must be reported within 4 hours and investigation must be completed and submitted within 24 hours.**

EMPLOYEE INFORMATION:

Employee Name: _____

Job Title: _____ Date of Birth: _____

Home Address: _____ Sex: M / F Date of Hire: _____

City/State/Zip Code:_____ Years in occupation: _____

Contact Number: _____

PROJECT INFORMATION:

Job Name: _____ Job #: _____

Job Address: _____ Length of time on job site: _____

Exact location of incident (Bldg/Level/Area): _____

Supervisor's Name: _____ Project Manager: _____

INCIDENT INFORMATION:

Date of Incident: _____ Time of Incident: _____ am / pm Date Reported: _____

Type of Incident: _____ Nature of Incident: _____ Time Reported: _____am / pm

Description of incident: _____

_____

_____

_____

_____

_____

Investigation Conducted by: _____ Email: _____

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CONSTRUCTION & DEVELOPMENT

PROPERTY DAMAGE INVESTIGATION REPORT

Employee Statement

Employee Name: _____ Job Number: _____

Title: _____ Trade: _____ Date of Incident: _____

Job Name: _____ Time of Incident: _____

1. Where were you when the incident occurred? _____
2. What activity were you performing at the time of the incident and what happened?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Was equipment involved in the incident? ☐ Yes ☐ No

   If yes, please provide the following information:

Type of Equipment:		**Serial Number:**	
Model:		**Owner of Equipment:**	

   Is a certification required to operate equipment? ☐ Yes (Provide a copy of certification) ☐ No

4. What do you think could have been done to prevent this type of incident from occurring?

_____

_____

Employee signature: _____ **Date:** _____

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PROPERTY DAMAGE INVESTIGATION REPORT

Witness Statement

Witness Name: _____

Title: _____ Trade: _____ Job Name: _____

Home Address: _____ Date of Incident: _____

Phone #: _____ Time of Incident: _____

Employer Name: _____

Employer Phone #: _____

1. Where were you when the incident occurred? _____
2. What activity were you performing at the time of the incident? _____
3. What activity was the injured employee performing? _____
4. Name of witnesses and/or other employees working in the area when the incident occurred:

Name	Email or Phone Number	Company

WITNESS Statement:

_____

_____

_____

_____

_____

_____

Signed by witness: _____ **Date:** _____

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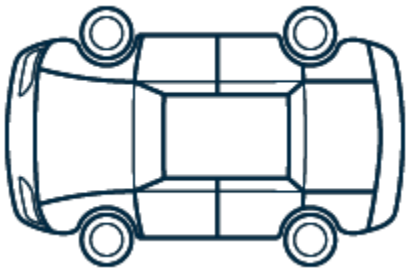
CONSTRUCTION & DEVELOPMENT

Auto Accident Report

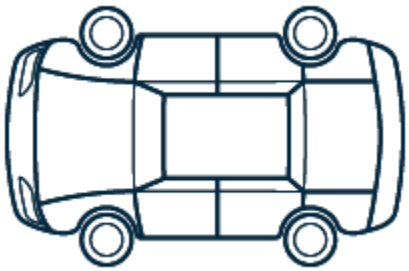
ACCIDENT LOCATION						
County			City			
Date of accident	Time of accident _____:_____ a.m. p.m.		# Vehicles involved			
Road/Street/Hwy			Intersection			
Did Police Officer investigate accident Yes No	Was traffic citation issued to driver #1 Yes No		#2 Yes No		#3 Yes No	
VEHICLE #1: Vehicle you were driving						
Driver Name (Last, First, Middle)	Street address		City		State	Zip
Driver's License # / Department #	State	Sex M F	Date of Birth	Age	Phone #	
Vehicle License # / Vehicle #	State	Vehicle Make	Vehicle Model	Vehicle Year	Vehicle Color	
Passenger 1 (Last, First, Middle)	Street address		City		State	Zip
Passenger 2 (Last, First, Middle)	Street address		City		State	Zip
Passenger 3 (Last, First, Middle)	Street address		City		State	Zip
VEHICLE #2: Other Vehicle(s) involved in accident						
Number of occupants in vehicle: _____	Number of injured occupants: _____					
Driver Name (Last, First, Middle)	Street address		City		State	Zip
Driver's License #	State	Sex M F	Date of Birth	Age	Phone #	
Vehicle License #	State	Vehicle Make	Vehicle Model	Vehicle Year	Vehicle Color	
Insurance Company	Policy #:		Policy Period:			
Vehicle Owner Name (Last, First, Middle)	Street address		City		State	Zip
Passenger 1 (Last, First, Middle)	Street address		City		State	Zip
Passenger 2 (Last, First, Middle)	Street address		City		State	Zip
Passenger 3 (Last, First, Middle)	Street address		City		State	Zip

Vehicle #1



Shade in damaged areas

Vehicle #2



Shade in damaged areas

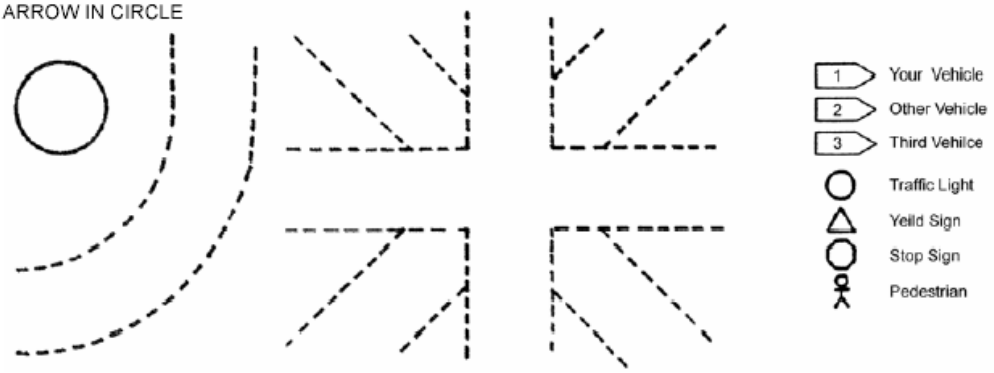
The TRADESGROUP
CONSTRUCTION & DEVELOPMENT

Auto Accident Report

Please complete this diagram. Show names of streets, direction and position of automobiles, and point of contact if possible. Use a solid line to show path before accident, dotted line to show path after accident.

Use one of these outlines to sketch the scene of your accident. Show names of streets, direction and position of automobiles, and point of contact. Use solid line to show path before accident, dotted line to show path after accident.

INDICATE NORTH WITH ARROW IN CIRCLE



LIGHT
(Check One)

Dawn — Daylight
Darkness-street lighted
Darkness-street not lighted
Dusk

ROAD CHARACTER
(Check Two)

Level — Curve
Hillcrest — Straight
On Grade — Road

WEATHER
(Check One)

Clear — Raining
Snowing — Fog

ROAD SURFACE
(Check One)

Dry — Muddy
Wet — Icy
Snowy

Description of incident:

The TRADESGROUP
CONSTRUCTION & DEVELOPMENT

Emergency and Medical Response Plan and Incident Reporting Chart

Minor Physical Injury

- Provide initial first aid care if you are trained to do so
- Notify your Supervisor, Claims and Safety Dept. via phone
- Call On-Site Health & Safety, 866-998-2750, or transport to designated clinic as directed by Claims or Safety
- **General Foremen**
  -Submit Incident Report within 24 hrs of incident to Claims and Safety Dept.

Major Physical Injury

- Includes: Death, loss of consciousness, uncontrollable bleeding, loss of limb, need of ambulance transport
- Initiate proper emergency services 911, if needed
- Secure scene, barricade area, if needed, and clear a path for emergency services
- Notify your Supervisor, Claims and Safety Dept. Immediately

Environmental Incident

- Stop work and remove employees from affected area
- Notify your Supervisor, Claims and Safety Dept. via phone
- Secure the scene as necessary and begin incident report process

Property Damage Incident

- Notify the Propety Owner
- Notify your Supervisor, Claims and Safety Dept. via phone
- For vehicle accidents, follow ACCO's accident reporting policy
- Secure the scene as necessary, begin incident report process, and take several photographs

Supervisors

-Document the incident via report form (reports are to be initiated before continuing regular work)

-Accompany injured employee to treating medical facility

-Follow up with injured employee

-Participate in investigation process

-Take several photographs of the scene/injury

https://thetradesgroup.com.com/safety-procedures/

Claims and Safety Department

-Ensure all appropriate notifications are made to management and client, as necessary

-Help to facilitate the appropriate care for employee

- Take several photographs of the scene/injury

-Follow up with Investigation and Safety Manager Incident Report

ON-SITE
HEALTH & SAFETY®

IN CASE OF INJURY

FOR ALL **LIFE THREATENING** INJURIES CALL **911**

LIFE THREATENING INJURIES ARE THOSE THAT INVOLVE:

- **LOSS OF CONSCIOUSNESS**
- **AIRWAY COMPROMISE**
- **BREATHING DIFFICULTY**
- **CIRCULATORY COMPROMISE**
- **OBVIOUS LONGBONE FRACTURES**
- **POSSIBILITY OF TRAUMATIC NECK OR BACK INJURY**
- **LARGE BURNS**
- **BURNS THAT INVOLVE THE FACE OR GENITAL AREA**

ALL OTHER INJURIES:

ON-SITE HEALTH & SAFETY

RESPONSE DIRECTLY TO YOUR WORKSITE

24 HOURS / 7 DAYS

866-998-2750

ALTERNATE AFTER-HOURS PHONE NUMBERS:

MOBILE: 925-525-9855 | 925-525-9851

Skip the phone call…**Schedule Online!**

www.OSHSdispatch.com

ON-SITE
HEALTH & SAFETY

The Trades Group Inc

COMPANY NAME

7V1NE4

CUSTOMER ID NUMBER

2HR7C0

PROTOCOL ID NUMBER

PLEASE HAVE YOUR ID NUMBERS READY WHEN YOU CALL FOR SERVICE

866-998-2750 ~ OSHSDISPATCH.COM

ON-SITE
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