

Safety Responsibilities PRODUCTION OFFICE COORDINATOR

Safety Program Information for Production Office Coordinator (POC)

The following information is for your specific position and is provided to help you understand your part in your show's Occupational Health and Safety Program.

Responsibilities of the Production Office Coordinator

The **Production Office Coordinator** will maintain a library of safety information including copies of all safety program documentation as described in the Occupational Health and Safety Program for Production. It is the POC's responsibility, along with the Production Manager (PM), to see to it that all necessary OHSP documentation (forms, certifications, etc.) are completed in a timely manner and forwarded to the Production Executive, Production Attorney and the **Production Safety Representative** as necessary

Training Documents

1. All productions are required to employ workers knowledgeable in the work they will be asked to do. Because there are many different ways proficiency can be documented, different Department Heads will submit varying evidence of training. All of it is important.
2. Check that Departments operating heavy equipment are turning in copies of Certification for each piece of equipment they will be asked to drive (e.g. Forklift Safety Card, Aerial Platform Training, powder-actuated tool operator's "Hilti Card," etc.) Keep them on file.
3. Some Department Heads will be sending copies of Safety Meetings they have conducted; others will send signed copies of Codes of Safe Practices (CSP's). Keep them on file.
4. Most importantly, make sure a signed **Acknowledgment Form** for receipt of **(Form 1) General Safety Guidelines for Production** is on file for all employees from all departments.
5. If you need help determining training requirements, or arranging training, **call the Production Safety Representative.**

Production Start-Up

Implement the Occupational Health and Safety Program:

1. As soon as possible, call the Production Safety Representative to arrange for a **Production Safety Orientation** for your PM, 1st AD, 2nd AD, Transportation Coordinator, Construction Coordinator, Special Effects and Stunt Coordinators, and all key Department Heads.
(Immediately prior to your first full production meeting is a good time to hold this orientation.)
2. Obtain and read the **Production Safety Manual** from the Production Safety Representative or **www.canadianproduction.com** the first week of employment. This manual is meant to provide guidance and clarification of possible question. Keep the manual in the production office at all times. A copy should be on all stages and locations as well.

Coordinate the documentation of all safety program activities:

See to it that the following have been turned into the Production Office, and copies sent to the Production Safety Representative at the beginning of the production:

1. Employee Acknowledgment of General Safety Guidelines for Production (Form 1)
2. Employee Acknowledgment of Additional Safety Guidelines for Special Effects (Form 1B)
3. OHSP Contact List (Form 2)
4. Serious Incident Reporting Procedures (Form 4)

On Production

1. See to it that the following are turned into the Production Office and copies sent to the Production Safety Representative on a regular basis:
 - a. Production Stage Hazard Assessment Checklist (Form 5)
 - b. Mill/Stage/Location Construction Hazard Assessment Checklist (Form 6)
 - c. Location Pre-Production Hazard Assessment Checklist (Form 7)
 - d. Location On-Production Hazard Assessment Checklist (Form 8)
 - e. Safety Guidelines for Extras and Theatrical Day Hires (Form 15)
 - f. Young and New workers orientation
2. See to it that the following are turned into the Production Office and copies sent to the Production Safety Representative as they are completed:
 - a. Accident Investigation Report (Form 9)
 - b. Hazard Notification (Form 10)
 - c. Notice of Unsafe Condition and Action Plan (Form 11)
 - d. Safety Warning Notice (Form 12)
 - e. Production Safety Meeting Report (Form 13)
 - f. Request for Employee Safety Training (Form 14)
 - g. First Aid Reports
 - h. Joint Occupational Health and Safety Committee minutes
 - i. Employer Reports of Injury or Occupational Disease (F7s)
 - j. Employer Incident and Investigation Reports
 - k. Right of Refusal of Medical Aid (Form 16)
 - l. Any special permits, environmental surveys, location safety reports, etc. daily Production Reports listing safety meetings, including key department head and new arrival meetings, stunt and special effects meetings, etc.
3. If your duties include distributing Calls Sheets, always attach any *AMPTP* or *ActSafe Safety Bulletins* or other notices deemed appropriate by your PM or 1st or 2nd AD and ensure they are referenced on the call sheet.

Injuries and Illnesses

1. You are to maintain a log of all injuries and illnesses to anyone on your show if either of the following is true:
2. You should receive a **First Aid Report** from your First Aid Attendant for every injured employee. If the worker requires additional medical attention beyond basic first aid, or misses any work beyond the date of the injury then you must fill out an **Employer's Report of Injury or Occupational Disease (F7)** and submit to WorkSafeBC within 3 working days. Once it has been determined that an F7 is required then an **Employers Incident and Investigation Report** will be required from the Joint Occupational Health and Safety Committee and must be submitted to WorkSafeBC within 48 hours.
3. If the patient has refused medical attention, you should also receive a completed **Right of Refusal of Medical Aid Form (Form 16)**. Please be sure to email these forms to the Production Safety Representative and the member union or BCCFU as required.

Serious Accidents, Injuries and Mishaps

Serious accidents, injuries and mishaps are incidents that require transportation by ambulance, visitation to the hospital by one or more employees, any treatments greater than general first aid or any serious property/asset damage.

In the event of a serious accident, injury or mishap, the **Production Manager**, or in his/her absence, the **1st Assistant Director** will follow the instructions on **Form 4 – Serious Incident Reporting Procedures**. It is the Production Office Coordinator’s responsibility to see that correct reporting instructions are available to the PM and 1st AD.

Show Wrap

1. See to it that all OHSP documents have been collected and forwarded to the **Production Safety Representative** or the **Production Executive** prior to closing the production office.
2. See to it that all borrowed safety equipment (harnesses, lanyards, ropes, etc.) has been returned to the Production Safety Representative.

Hazardous Waste Disposal

It is Company policy that all chemicals will be disposed of in accordance with the laws of the city, county and state in which they are used. If you need to arrange for the disposal of paint or other chemicals, contact the Production Safety Representative.

OCCUPATIONAL HEALTH AND SAFETY CONTACTS FOR PRODUCTION

Production Name:		To Be Completed By:	<i>Production Office Coordinator</i>
Copies Sent To:	<i>Safety Dept.</i>	To Be Stored By:	<i>Production Office Coordinator</i>
Production Location:		Today's Date:	
Special Instructions:	When: <i>At beginning of production.</i> Frequency: <i>Once, unless contact info changes.</i>		

Position	Name	Office Phone	Emergency Phone
Unit Production Manager			
1st Assistant Director/ Stage Manager			
Construction Coordinator			
Transportation Coordinator			
Production Executive			
Production Attorney			
Safety Representative			

SERIOUS INCIDENT REPORTING PROCEDURES

Incidents that result in transportation by ambulance, visitation to the hospital by one or more employees, any treatments other than general first aid, death or serious injury or illness to an employee, or any serious property/asset damage, must be reported as follows:

Unit Production Manager Responsibilities:

In the event of a serious accident, injury or mishap, AFTER ALL NECESSARY EMERGENCY PERSONNEL ARE CALLED, the UPM should contact the PRODUCTION EXECUTIVE WITHOUT EXCEPTION.

Name: _____ Office: _____ Cell: _____

If you are unable to reach your Production Executive you should call Sue Palladino, Executive Vice President of Production:

Office: (818) 954-7171, Cell: (818) 257-1202.

After discussion with your Production Executive and with her/his instruction, the following people will be notified:

- Shane Rogers of WBSF Safety & Environmental Affairs Cell: (250) 883-9919; Safety Hotline: (877) 566-8001
- Amanda Cooper of WB Risk Management Office: (818) 977-3277; Cell: (818) 438-7295
- Sam Wolfson of Labor Relations* Office: (818) 954-7269; Cell: (818) 219-3218
- Tammy Golihew of WBTV Worldwide Publicity Office: (818) 954-4855; Cell: (310) 779-9724

**Under the union collective bargaining agreements, union notification is required of any injury, regardless of the severity.*

If the incident occurred within the Province of British Columbia and resulted in transportation by ambulance, visitation to the hospital by one or more employees, death or serious injury or illness to an employee, or any treatments other than general first aid, WorkSafeBC must be notified IMMEDIATELY on the EMERGENCY LINE at 604-276-3301. The accident/incident site must be secured and left undisturbed (except to rescue the injured or prevent further injuries) until a WorkSafeBC representative arrives to conduct an investigation, or informs you that securing the site is unnecessary. An "Employer's Incident Investigation Report (EIIR)" should be completed by the Production. Your Production Safety Representative will assist you. The form is available at www.canadianproduction.com.

Information which is required to be reported:

- Time and date of accident.
- Employer's name, address and telephone number.
- Name and job title of person reporting the accident.
- Address of site of accident or event.
- Name of person to contact at accident site.
- Name and address of injured employee(s).
- Nature of injury.
- Location where injured employee(s) was (were) moved to.
- List and identities of other law enforcement agencies present at the accident site.
- Description of accident and whether the accident scene has been altered.

NOTE: Failure to notify WorkSafeBC of a serious injury or fatality will be considered a breach of section 172 of the Workers Compensation Act, and may result in an administrative penalty.

The Production Safety Representative will direct you to complete an **Employer's Incident Investigation Report (EIIR)**. The completed report should be sent to the Production Safety Representative and Labor Relations for review and approval, and then sent to WorkSafeBC. The approved EIIR should also be shared with the production's Health & Safety Committee and the BC Union Council.

Any accident should be noted on the back of the Production Report on the date the accident occurred by identifying only the name of injured employee and classification.

CAUTION: Written and/or verbal statements should not be taken unless authorized by the Studio Legal Department. Speculation regarding the cause(s) of accident(s) are not to be included as part of any investigation report. Speak with your Production Safety Representative for direction.

Set Medic/First Aid Attendant Responsibilities:

1. Notify the UPM of the injury.
2. Provide the patient with **Workers Compensation Form** or local equivalent. (The patient must sign and date a receipt. If the patient refuses the form, be sure to document this in your notes.)
3. FAX completed forms to the appropriate **Workers Compensation Department**:
 - a) Warner Bros.: (818) 977-6787
 - b) Cast & Crew: (818) 848-4614
 - c) Entertainment Partners: (818) 559-3283
 - d) Production Safety Representative: (818) 954-2805
4. SEND a completed copy of the form to your **Production Executive** with that day's production report.
5. Fill out **Employer's Report of Injury or Occupational Disease (Form 7)** or local equivalent. Record the patient's recounting of events in quotes. DO NOT SPECULATE.
6. FAX completed Form 7 (or local equivalent) to the **Production Safety Representative** at (818) 954-2805.
7. Complete a **Refusal of First Aid** form if the employee refuses to be treated at the scene of the incident or transported to the hospital.

Under the guidance and direction of the Studio Legal Department, the Production Safety Representative will conduct any additional accident investigations necessary.



As an employer, the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

- Online — The quickest and easiest option:** The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to worksafebc.com and select "Report injury or illness."
- Fillable PDF form:** Type in your details online, print the form, and submit it by **fax** or **mail**. Go to worksafebc.com and select "Report injury or illness."
- Paper form:** Clearly **print** details, sign the form, and submit it by **fax** or **mail**.

Fax: 604.233.9777 in Greater Vancouver or **toll-free** within BC at 1.888.922.8807

Mail: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

Employer information			WorkSafeBC claim number (if known)		
Employer's name (as registered with WorkSafeBC)			Type of business		
WorkSafeBC account number		Classification unit number		Operating location number	
Employer address line 1 (mailing)		Employer contact last name		First name	
Employer address line 2 (mailing)		Employer contact telephone (and area code)		Extension	Employer contact fax (and area code)
City	Province/state	Employer payroll contact last name		First name	
Country (if not Canada)	Postal code/zip	Employer payroll contact telephone (and area code)		Extension	Employer payroll contact fax (and area code)

Worker information

Worker last name		First name		Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Date of birth (yyyy-mm-dd)		Home phone number (include area code)		Social insurance number		
Address line 1			Address line 2			
City		Province/state	Country (if not Canada)		Postal code/zip	

1. What is the worker's occupation?		2. Has the worker been employed by this firm for less than 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		3. If yes, start date (yyyy-mm-dd)	
4. At the time of injury, was the worker (check all that apply)					
<input type="checkbox"/> Permanent	<input type="checkbox"/> Apprentice	<input type="checkbox"/> Self-employed		<input type="checkbox"/> Casual	
<input type="checkbox"/> Temporary	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Principal/partner or relative of employer		<input type="checkbox"/> Other (specify)	
<input type="checkbox"/> Full time	<input type="checkbox"/> Student	<input type="checkbox"/> Fisher			
<input type="checkbox"/> Part time	<input type="checkbox"/> New entrant to workforce	<input type="checkbox"/> Hired on a contract basis			

Incident information

5. Date of incident (yyyy-mm-dd)		Time of incident (hh:mm) <input type="checkbox"/> am <input type="checkbox"/> pm OR		6. Period of exposure resulting in occupational disease (yyyy-mm-dd) From To	
7. Did worker report injury or exposure to employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. The injury or disease was first reported to employer on (yyyy-mm-dd) (please check one) To: <input type="checkbox"/> First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other (specify)			
9. Name of person reported to					
10. Describe how the incident happened			11. Describe the injury in detail (what part of the body was injured)		
			12. Side of body injured <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable		
13. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)					
14. Did the injury(ies) or exposure result from a specific incident? <input type="checkbox"/> Yes <input type="checkbox"/> No					





If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

Worker last name		First name		Middle initial	WorkSafeBC claim number (if known)
Social insurance number	Personal health number (CareCard)		Date of incident (yyyy-mm-dd)		Date of birth (yyyy-mm-dd)

15. Contributing factors — select **at least one**, and as many as applicable

<input type="checkbox"/> Lifting	<input type="checkbox"/> lb	<input type="checkbox"/> kg	<input type="checkbox"/> Struck	<input type="checkbox"/> Assault
<input type="checkbox"/> Overexertion			<input type="checkbox"/> Crush	<input type="checkbox"/> Motor vehicle accident
<input type="checkbox"/> Repetitive (activity repeated over and over again)			<input type="checkbox"/> Sharp edge	<input type="checkbox"/> Unsure/other (please explain below)
<input type="checkbox"/> Slip or trip			<input type="checkbox"/> Fire or explosion	
<input type="checkbox"/> Twist			<input type="checkbox"/> Harmful substances in the work environment	
<input type="checkbox"/> Fall			<input type="checkbox"/> Animal bite	

16. Were there any witnesses?
 Yes No

17. Did the incident occur in British Columbia?
 Yes No

18. Were the worker's actions at time of injury for the purpose of your business?
 Yes No

19. Did the incident occur on employer's premises or an authorized worksite?
 Yes No

20. Did the incident happen during the worker's normal shift?
 Yes No

21. Was the worker performing their regular duties at the time of the incident?
 Yes No

22. Did the worker receive first aid?
 Yes No Date (yyyy-mm-dd) ◆

If yes, please provide first aid attendant name (if known)

23. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner?
 Yes No Date (yyyy-mm-dd) ◆

If yes, please provide provider name (if known)

If yes, please provide provider address (if known)

24. Are you aware of any recent pain or disability in the area of the worker's reported injury?
 Yes No

25. Do you have any objections to the claim being allowed?
 Yes No ◆

If yes, please explain

Wage information

26. Did the worker miss any time from work beyond the date of injury or exposure?
 Yes No

If no work was missed and no change to duties/pay, proceed to bottom of page to sign, date, and submit this report. If work was missed or if duties/pay have been modified, please answer all questions on this form.

27. Provide the **base salary** amount for this employment position at the time of injury
 \$ _____ Hourly Daily Weekly Monthly Yearly

28. Does worker receive other amounts of compensation in addition to **base salary**?
 Does worker receive vacation pay on every cheque? Yes No
 If yes, vacation pay _____%

29. If worker is disabled from work, will you continue to pay:
Base salary? Yes No
 Other amounts of compensation in addition to **base salary**? Yes No
 Will worker receive vacation pay on every cheque? Yes No
 If yes, vacation pay _____%

Please select check boxes for any of the following amounts worker receives in addition to **base salary** AND provide the amount for each:

<input type="checkbox"/> Tips and gratuities \$ _____	<input type="checkbox"/> Room and board \$ _____
<input type="checkbox"/> Shift differential \$ _____	<input type="checkbox"/> Other \$ _____
<input type="checkbox"/> Overtime \$ _____	

Please select check boxes for any of the following amounts worker will continue to receive in addition to **base salary** AND provide the amount for each:

<input type="checkbox"/> Tips and gratuities \$ _____	<input type="checkbox"/> Room and board \$ _____
<input type="checkbox"/> Shift differential \$ _____	<input type="checkbox"/> Other \$ _____
<input type="checkbox"/> Overtime \$ _____	

30. Provide the amount of **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure
 \$ _____ 3 months 12 weeks

31. Does the worker have a fixed-shift rotation? Yes No

32. If no, please explain

33. If yes, show the normal work week by entering the paid hours

Sun	Mon	Tues	Wed	Thu	Fri	Sat

34. Did the worker continue to work past day of injury?
 Yes No

35. Last day worked (yyyy-mm-dd)

36. Number of hours scheduled to work on last day worked

37. Number of hours worked on last day

38. Number of hours paid by employer on last day worked





If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

Worker last name	First name	Middle initial	WorkSafeBC claim number (if known)
Social insurance number	Personal health number (CareCard)	Date of incident (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)

Return-to-work information

39. Has the worker returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
40. If Yes : Date (yyyy-mm-dd) Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
41. If No : Do you have any modified or transitional duties available? <input type="checkbox"/> Yes <input type="checkbox"/> No Have the modified or transitional duties been offered to the worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	42. If yes, please describe modified or transitional duties

Signature and report date

43. Employer signature	44. Employer title	45. Date of report (yyyy-mm-dd)
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For assistance, please call our Claims Call Centre at 604.231.8888 or toll-free within Canada at 1.888.967.5377, M-F, 8:00 a.m. to 6:00 p.m.

Please note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns. **Impartial advice on WorkSafeBC claims** — To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their website at www.labour.gov.bc.ca/eao/.

Lower Mainland
604.713.0303 (Richmond)
Toll-free within Canada 1.800.925.2233

Abbotsford, Kamloops, Kelowna, Nanaimo, Trail, Prince George, Victoria
Toll-free within Canada 1.800.925.2233

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.



Employer Incident Investigation Report (EIIR)

Please refer to the companion [quick guide](#) for assistance completing the investigation and this form.

1. Employer's information

Employer's name (legal name and trade name)		
WorkSafeBC account number	Operating location number	
Employer's head office address		
City	Province	Postal code
Employer's representative's name		Phone number (include area code)
Email address		

2. Injured persons

Last name	First name	Job title
a)		
b)		
c)		
d)		

3. Place, date, and time of incident

Location where incident occurred (street address or GPS coordinates)		
City (nearest)	Province	Postal code
Date of incident (yyyy-mm-dd)	Time of incident	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.

4. Type of occurrence (select all that apply)

<input type="checkbox"/> Death of a worker	<input type="checkbox"/> Dangerous incident involving explosives other than blasting incident
<input type="checkbox"/> Serious injury to a worker	<input type="checkbox"/> Diving incident, as defined by regulation
<input type="checkbox"/> Major structural failure or collapse Major	<input type="checkbox"/> Incident of fire or explosion with potential for serious injury
<input type="checkbox"/> release of hazardous substance Blasting	<input type="checkbox"/> Minor injury or no injury but had potential for causing serious injury
<input type="checkbox"/> accident causing personal injury	<input type="checkbox"/> Injury requiring medical treatment beyond first aid

An incident investigation report is NOT required under the *Workers Compensation Act* if none of the above applies or if this incident is a vehicle accident occurring on a public street or highway.

5. Report type (select all that apply)

If this is a revised version of a previous report, please check here

<input type="checkbox"/> Preliminary Investigation Report Report date (yyyy-mm-dd) Only provide to a WorkSafeBC officer if requested Officer's name	<input type="checkbox"/> Interim Corrective Action Report Report date (yyyy-mm-dd)	<input type="checkbox"/> Full Investigation Report Report date (yyyy-mm-dd) Must be provided to WorkSafeBC within 30 days* Fax 1.866.240.1434 Date sent (yyyy-mm-dd)	<input type="checkbox"/> Full Corrective Action Report Report date (yyyy-mm-dd)
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Employer Incident Investigation Report (EIIR)

6. Witnesses

Last name	First name	Job title
a)		
b)		
c)		

7. Other persons whose presence might be necessary for proper investigation

Last name	First name	Job title
a)		
b)		

8. Sequence of events that preceded the incident

Required in Preliminary Report. Update in Full Report if necessary. Describe events earlier that day or even in previous years that led up to the incident. Examples may include events such as training given or changes in equipment, procedures, or company management.

9. Unsafe conditions, acts, or procedures that significantly contributed to the incident

Required in all reports. Describe anything, or the absence of anything, that contributed to the hazard such as poor housekeeping or poor visibility, using equipment without guards, or the lack of safe work procedures.

10. Nature of the serious injury (optional — complete only if there has been an injury)

- | | |
|---|---|
| <input type="checkbox"/> Life threatening or resulting in loss of consciousness | <input type="checkbox"/> Punctured lung or other serious respiratory condition |
| <input type="checkbox"/> Major broken bones in head, spine, pelvis, arms, or legs | <input type="checkbox"/> Injury to internal organ or internal bleeding |
| <input type="checkbox"/> Major crush injuries | <input type="checkbox"/> Injury likely to result in loss of sight, hearing, or touch |
| <input type="checkbox"/> Major cut with severe bleeding | <input type="checkbox"/> Injury requiring CPR or other critical intervention |
| <input type="checkbox"/> Amputation of arm, leg, or large part of hand or foot | <input type="checkbox"/> Diving illness such as decompression sickness or near drowning |
| <input type="checkbox"/> Major penetrating injuries to eye, head, or body | <input type="checkbox"/> Serious chemical or heat/cold stress exposure |
| <input type="checkbox"/> Severe (third-degree) burns | <input type="checkbox"/> Other (specify) |

Employer Incident Investigation Report (EIIR)

11. Brief description of the incident

Required in Preliminary Report. Briefly, summarize the sequence of events, the unsafe factors, and the resulting injury, if any.

12. Corrective actions identified and taken to prevent recurrence of similar incidents

Action (Required in Preliminary Report and Interim Corrective Action Report. Update in Full Report, if necessary.)	Action assigned to (name and job title)	Expected completion date (yyyy-mm-dd)	Completed date (yyyy-mm-dd)
a)			
b)			
c)			
d)			
e)			

13. Explanation of blank areas on this Preliminary Report, if any

If there are blank areas, describe the circumstances beyond your control that explain this lack of information.

14. Persons who carried out or participated in the preliminary investigation

Representative	Name	Job title	Signature (optional)	Date signed (yyyy-mm-dd)
Employer representative (required)				
Worker representative (required)				
Other				
Other				

End of report

Completing all the sections above satisfies the requirements for a Preliminary Investigation Report and an Interim Corrective Action Report.

Note: If this was a simple investigation and **all needed corrective actions have been completed within 48 hours**, the Preliminary and Full Investigation portions of the report can be completed at the same time. If so, you can check both the Preliminary Investigation Report and the Full Investigation Report boxes in section 5 on page 1.

As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.

Employer Incident Investigation Report (EIIR)

15. Determination of causes of incident

Required in Full Report. Analyze the facts and circumstances of the incident to identify underlying factors that led to the incident. Underlying factors include factors that made the unsafe conditions, acts, or procedures in the Preliminary Report possible. Update items from section 9, if needed.

16. Full description of the incident

Required in Full Report. Use the brief description from the Preliminary Report and update it, if necessary.

17. Additional corrective actions necessary to prevent recurrence of similar incidents

Additional corrective action (Required in Full Report and Full Corrective Action Report.)	Action assigned to (name and job title)	Expected completion date (yyyy-mm-dd)	Completed date (yyyy-mm-dd)
a)			
b)			
c)			
d)			

18. Persons who carried out or participated in the full investigation

Representative	Name	Job title	Signature (optional)	Date signed (yyyy-mm-dd)
Employer representative (required)				
Worker representative (required)				
Other				

19. Other relevant workplace parties

Company name	Contact person	Contact number or email address
a)		

End of report

Completing all the sections above satisfies the requirements for a Full Investigation Report and a Full Corrective Action Report.

Employers are required to submit **full** investigation reports to WorkSafeBC **within 30 days* of the incident**. Reports may be submitted by fax to 604.276.3247 (Greater Vancouver), toll-free fax 1.866.240.1434, or by mail to PO Box 5350, Stn Terminal, Vancouver BC V6B 5L5. Do **NOT** submit a preliminary report unless you have been so directed by a WorkSafeBC officer.

* Employers can request an extension from a WorkSafeBC officer, **if the full investigation cannot be completed within 30 days**.

As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.