



**ADVANCED EXPLORATIONS INC.  
BEHAVIOR BASED SAFETY  
ACCIDENT STATISTICS REPORT**

Name of Injured:		Payroll nr:		Sex:		Age:		Hire date:		WSCC ref nr:					
Occupation (at time of injury):								Regular <input type="checkbox"/>		Relief <input type="checkbox"/>		Temporary <input type="checkbox"/>			
Experience in occupation:		0-6mo <input type="checkbox"/>		7-12mo <input type="checkbox"/>		1-2yr <input type="checkbox"/>		3-5yr <input type="checkbox"/>		6-10yr <input type="checkbox"/>		11-15yr <input type="checkbox"/>		>15yr <input type="checkbox"/>	
Identify common core program for which injured is accredited:				Mine <input type="checkbox"/>		Mill <input type="checkbox"/>		Diamond drill <input type="checkbox"/>		Supervisor <input type="checkbox"/>					
Identify MHSA Training program for which the injured is accredited:				Surface <input type="checkbox"/>		Underground <input type="checkbox"/>		Coal <input type="checkbox"/>							
What training had been given in the safe performance of the task? (multiple selections possible):															
Apprenticeship <input type="checkbox"/>		Common Core Modules <input type="checkbox"/>		Task Training <input type="checkbox"/>		Specialty Modules <input type="checkbox"/>		Specify							
WHMIS <input type="checkbox"/>		Other <input type="checkbox"/>		Specify		Not Applicable <input type="checkbox"/>		Not Trained <input type="checkbox"/>							
At time of incident, employee was on:															
Individual/Small Crew Incentive <input type="checkbox"/>				Company/Department Incentive <input type="checkbox"/>				Not on Incentive <input type="checkbox"/>							
Shift Time		Shift Type				Overtime Shift									
Start		Steady		<input type="checkbox"/>		Overtime Hours		<input type="checkbox"/>							
End		Rotating		<input type="checkbox"/>		Not Overtime		<input type="checkbox"/>							
How many complete shifts has been worked since the last 24 hour break from work?															
<b>First Aid</b>															
Describe injury (nature and part(s) of body):															
Number of persons requiring outside medical aid due to this incident:															
To your knowledge, has the worker had a previous similar disability?															
Has modified work been assigned?						Describe:									
Was employee sent/taken to doctor?			By whom?			Date:			First Aid Att. Name:						
<b>Doctor</b>															
Name of Doctor:															
Address of Clinic or Hospital:									Phone:						
<b>Team</b>															
Investigation Team Members:									Date of Investigation:						
<b>Review</b>															
Health and Safety Committee Rep (Worker Rep):															
Signature:									Date:						
Health and Safety Committee Rep (Company Rep):															
Signature:									Date:						
Immediate Supervisor:															
Signature:			Title:			Date:									
Manager:															
Signature:			Title:			Date:									
Injured Worker:															
Signature:									Date:						