

Belair Excavating, Inc.

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APR 29 2011
SOUTH DAKOTA PUBLIC
UTILITIES COMMISSION

Project Forms Packet

For onsite use

Belair/Odrive/safetyforms/

"FOR INTERNAL USE ONLY"

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BELAIR

EXCAVATING

ACCIDENT, INCIDENT & DAMAGE REPORT

PLEASE COMPLETE ALL BLANKS

Day of Incident: Date of Incident: / / Person Reporting Incident: Supervisor:
S M T W T H F Sat (Rev. 5/5/08; All Other Blank Reports before this Date are Void)

Unit Involved in Incident: # _____	<input type="checkbox"/> Dozer <input type="checkbox"/> Forklift <input type="checkbox"/> Bobcat <input type="checkbox"/> Front End Loader <input type="checkbox"/> Backhoe <input type="checkbox"/> Off Road <input type="checkbox"/> Truck <input type="checkbox"/> Packer <input type="checkbox"/> Other	Describe Location of Incident: _____ _____ _____	Person(s) Involved in Incident: _____ _____ _____	Belair Job No.: # _____ Belair Job Name: _____
---------------------------------------	---	---	--	---

Please fill out this report completely & accurately, within 12 hours. The same day is the best.

WHO: *Who was notified of accident?*
 Tom Ludwig (All Reports)
 Bryan Cook (CO.Reports)
 Rebecca English (FL Reports)
 John Stenglein (1st Reports of Inj., GL & Auto. MN.)
 Other (Who?) _____

WHAT:
What happened? _____

What damage or injury was done? _____

WHY: *Describe in your words, why did it happen?*
Primary or Indirect Cause. A Hazard exists = *An unsafe slope exists, a trench box or ladder is not in place, or debris or a shovel is in your way.*
Secondary or Direct Cause. The Hazard is was not removed, or an Injury Prevention Measure was not put in place = *A poor slope is was not fixed, a trench box or ladder not installed.* _____

WHEN: *When did it happen?* Time: _____:_____: AM PM

HOW:
How did it occur? (In your own words) _____

PREVENTION: Very Important
How could it have been prevented? (Remove the hazard, Correct the Slopes, Install Trench Boxes, Wear Gloves, Re- Mark Line Underground Facilities, Pass information onto the Next Machine Operator. etc.) _____

Did you take *photographs*? Yes No Why not? _____
 Were *Police notified*? Yes No Case No/Contact Info _____
 Were *locates current*? Yes No If no, why not? _____
 Will Belair be *billed or fined*? Yes No If yes, approximately how much? \$ _____ < + - >
 Names of *witnesses*: _____
 Did you get *business card(s)*? Yes No Why not? _____
 If utility involved, *utility name and contact person(s)*: _____
Did you send all the involved parties in for a post accident drug/alcohol test? Required for Significant Injuries or \$1,000 + damage or as determined by DOT Regulation/State Safety Coord. () Yes/Non-DOT () Yes/DOT () No-why not?: _____

Other remarks or comments: _____

Signed: _____ **Signed:** _____ **Approved:** _____
Person Involved In Incident Date *Person Reporting Incident* Date *Safety Director or Associate*
(Worker) *(Super)*

TWO SIGNATURES REQUIRED
DIAGRAM ON PAGE 2 REQUIRED

Date **Report** Received _____
 Date **Incident** Occurred _____
 Initial upon Viewpoint Input _____

NOTE: All incidents/accidents, no matter how small, are reportable to the MN Office within 12 hours, in writing, per Company Guidelines. Always carry an updated incident report form with you. (Rev. 05-05-08)

EMERGENCY PROCEDURES

1. Assess the situation. *Don't become a second victim.* Think before you assist. (Gases, electrical shock, etc.) You won't be any help if you get killed trying to help. Many do. Stay out of cave-ins.
2. Get help – call "911" (or ask someone else to call 911). Mandatory by law if a gas pipe is hit.
3. Provide emergency measures until help arrives (CPR/first aid, etc.) **Good Samaritan law covers your mistakes.** It is better to *do something* rather than nothing when it comes to helpless victims.
4. **Fill out incident report in complete detail.** Answer every question and give enough information so our Safety Committee and office can properly investigate incident and keep us all out of trouble. *It helps us all to develop a solution in order to prevent it from ever happening again.*

WORKMAN'S COMP/INJURY RELATED

FILL OUT FIRST REPORT OF INJURY (Separate form. Specific to state: MN, CO, FL)

1. Is this injury related to your work for Belair Excavating? () YES () NO
2. Were you employed by anyone else or self employed at the time of this injury? () YES () NO
If yes, provide Employer name, address, phone:
3. Did you have any prior injuries or pain to any of the body parts injured in this accident? Please be specific. _____

IMPORTANT: DIAGRAM/MAP REQUIRED

N
W ↑ E
S

A rough sketch is required here
(Please orient north the best you can)

Additional Information & Comments:

First Report of Injury

See Instructions on Reverse Side
 PRINT or TYPE your responses.
 Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA Case #					
3. DATE OF CLAIMED INJURY		4. Time of injury		5. Time employee began work on date of injury			
		<input type="checkbox"/> am <input type="checkbox"/> pm		<input type="checkbox"/> am <input type="checkbox"/> pm			
6. EMPLOYEE Name (last, first, middle)				7. Gender		8. Marital Status	
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Married <input type="checkbox"/> Unmarried	
9. Home Address				10. Home phone #		11. Date of birth	
City		State		Zip Code		12. Occupation (Union?)	
						13. Regular department	
15. Average weekly wage		16. Rate per hour		17. Hours per day		18. Days per week	
						19. Employment Status	
						<input type="checkbox"/> Full time <input type="checkbox"/> Seasonal <input type="checkbox"/> Part time <input type="checkbox"/> Volunteer	
20. Weekly value of:		Meals		Lodging		21. Apprentice	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Tell us how the injury occurred and what the employee was doing before the incident (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."							
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.				24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.			
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate name and address of place of occurrence				26. Date of first day of any lost time		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI	
				28. Date employer notified of injury		29. Date employer notified of lost time	
				30. Return to work date		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone)				33. HOSPITAL/CLINIC (name and address) (if any)		34. Emergency Room Visit <input type="checkbox"/> Yes <input type="checkbox"/> No	
						35. Overnight in-patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
36. EMPLOYER Legal name BELAIR BUILDERS, INC.				37. EMPLOYER DBA name (if different) BELAIR EXCAVATING			
38. Mailing address 2200 OLD HIGHWAY 8 NW				39. Employer FEIN 41-0997613		40. Unemployment ID#	
City NEW BRIGHTON		State MN		Zip Code 55112		41. Employer's contact name and phone # TOM LUDWIG (651) 717-3394	
42. Physical address (if different)				43. Witness (name and phone)			
City		State		Zip Code		44. NAICS code 23891	
						45. Date form completed	
46. INSURER name				51. CLAIMS ADMIN COMPANY (CA) name (check one) SEABRIGHT INSURANCE / 888-782-6515			
				<input checked="" type="checkbox"/> Insurer <input type="checkbox"/> TPA			
47. Insured legal name				52. CA address 161 N. CLARK STREET, SUITE 3525			
48. Policy # or self-insured certificate #				City CHICAGO		State IL	
						Zip Code 60601	
49. Insurer FEIN		50. Date insurer received notice		53. CA FEIN		54. Claim #	

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)		Social Security #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ()		OSHA Log #
Employee's street address				City	State	Zip code	
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown		Date of hire / /	Occupation	Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown		For Division use only
Employer's name Belair Builders, Inc. dba Belair Excavating			Employer's Federal ID # 41-0997613	Employer's phone # (303) 394-1300		SOI	
Employer's mailing address 9405 Alton Court				City Henderson	State CO	Zip code 80640	POB
Average weekly wage at time of injury \$ _____ <small>(see instructions on reverse side)</small>		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance			NOI
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are wages continued per C.R.S. 8-42-124? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No			Coder
Injury/illness date / / <small>(See instructions on reverse side)</small>	Time employee began work _____ a.m. _____ p.m.	Injury time _____ a.m. _____ p.m. <input type="radio"/> unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /	
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death:			Injury occurred because of <input type="radio"/> Intoxication <input type="radio"/> Safety violation <input type="radio"/> Not applicable		
Tell us the part of body that was affected				Tell us the nature of the injury/illness ²			
What was the employee doing just before the accident occurred? ³							
Tell us how the injury occurred ⁴				What object or substance directly harmed the employee? ⁵			
Did injury occur on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code	Initial treatment (check one) <input type="checkbox"/> None <input type="checkbox"/> Emergency room <input type="checkbox"/> Minor on-site <input type="checkbox"/> Hospital >24 hrs <input type="checkbox"/> Clinic/hospital			Was the employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of witnesses				Name of employer representative notified			
Name and address of treating doctor or other health care professional				Name and address of facility where treated			
Completed by (name)		Title	Phone # ()	Date completed / /			
The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.							
Name of insurance company SeaBright Insurance Co. / 888-782-6515				Address 161 N. Clark Street, Suite 3525, Chicago, IL 60601			
Name of third party administrator (if applicable)				Address			
Adjuster name				Adjuster phone #			
Policy #	Carrier claim #	Date insurer received first report / /		Block #	Adj. Code		

FIRST REPORT OF INJURY OR ILLNESS
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
 or contact your local EAO Office
 Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE		EMPLOYEE INFORMATION	
NAME (First, Middle, Last)		Social Security Number	Date of Accident (Month-Day-Year)
HOME ADDRESS		Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	
Street/Apt #:		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)	
City: _____ State: _____ Zip: _____			
TELEPHONE Area Code Number			
OCCUPATION	INJURY/ILLNESS THAT OCCURRED		PART OF BODY AFFECTED
DATE OF BIRTH	SEX		
_____ / _____ / _____	<input type="checkbox"/> M <input type="checkbox"/> F		

EMPLOYER INFORMATION		DATE FIRST REPORTED (Month/Day/Year)	
COMPANY NAME: <u>Belair Builders, Inc.</u>		FEDERAL I.D. NUMBER (FEIN)	POLICY/MEMBER NUMBER
D. B. A.: <u>Belair Excavating</u>		41-0997613	
Street: <u>2200 Old Highway 8 NW</u>		NATURE OF BUSINESS	
City: <u>New Brighton</u> State: <u>MN</u> Zip: <u>55112</u>		<u>Earthwork, Utilities, Concrete</u>	
TELEPHONE Area Code Number		DATE EMPLOYED	PAID FOR DATE OF INJURY
<u>239-513-1300</u>		_____ / _____ / _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S LOCATION ADDRESS (if different)		LAST DATE EMPLOYEE WORKED	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
Street: <u>6220 Taylor Road Suite 106</u>		_____ / _____ / _____	
City: <u>Naples</u> State: <u>FL</u> Zip: <u>34109</u>		RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP
LOCATION # (if applicable)		IF YES, GIVE DATE	_____ / _____ / _____
PLACE OF ACCIDENT (Street, City, State, Zip)		DATE OF DEATH (if applicable)	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK
Street: _____		_____ / _____ / _____	\$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO
City: _____ State: _____ Zip: _____		AGREE WITH DESCRIPTION OF ACCIDENT?	Number of hours per day _____
COUNTY OF ACCIDENT _____		<input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per week _____
			Number of days per week _____
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 440.105(7), F.S. I have reviewed, understand and acknowledge the above statement.			NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
EMPLOYEE SIGNATURE (if available to sign)		DATE	
EMPLOYER SIGNATURE		DATE	AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached		<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3) Employee's 8 TH Day of Disability _____ / _____ / _____ Entity's Knowledge of 8 TH Day of Disability _____ / _____ / _____	
<input type="checkbox"/> 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date _____ / _____ / _____		Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____	
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY			
Penalty Amount Paid in 1 st Payment \$ _____		Interest Amount Paid in 1 st Payment \$ _____	
REMARKS:		INSURER NAME	
		CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE <u>SeaBright Insurance Co.</u> <u>161 N. Clark Street, Suite 3525</u> <u>Chicago, IL 60601</u> <u>888-782-6515</u>	
INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	
		23891	
SERVICE CODE/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #		



**AUTHORIZATION FOR MEDICAL RECORDS
AND COMMUNICATIONS RELEASE**

Claim #:
Clamant:

I have submitted a worker's compensation claim to my employer and I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic, pharmacy, or other medically related facility, insurance company or other organization, corporation, institution or person, that has any records or knowledge of my mental or physical health, history, condition or well-being, to supply all such information to my employer or its insurance carriers, third party claims administrators, attorneys, consultants, nurses and vendors which may participate in coordination of my medical or vocational rehabilitation, or make a determination of my entitlement to benefits under the Workers' Compensation Act.

I specifically authorize any treating physician or other medical care provider to communicate orally or in writing with my employer or its insurance companies, including SeaBright Insurance Company, claims administrators, rehabilitation or medical management consultant, nurses, vocational counselors, or attorneys, as to my past and future care and treatment, and as to any other issues including diagnosis, prognosis, causal connection, treatment plan, and ability to work. I hereby waive my physician-patient privilege and any privacy regulations under the Health Insurance Portability & Accountability Act. In conjunction with this release, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

NAME (PLEASE PRINT)

SIGNATURE

DATE



WORKERS' COMPENSATION Rx PROGRAM



The top portion of this form must be completed before giving it to your pharmacist.

Injured Employee: _____ Social Security # _____ Date of Injury: _____

Employee Phone: _____ Employee Date of Birth: _____ Description of Injury: _____

Employer Name: _____ Employer Representative: _____ Phone: _____

To Employee:

On your first visit, please give this notice to any pharmacy listed on this panel to expedite the processing of your approved workers' compensation prescriptions.

To Pharmacist:

This employer has selected MSC – Medical Services Company to administer its workers' compensation prescription drug program through the RESTAT network. For immediate authorization and on-line billing information contact MSC at: 1-800-848-1989 ext 1414, state that you have received a letter of intent and give the MSC patient care coordinator the control number located in the bottom right hand corner of this form.

CHAINS PARTICIPATING IN THE PHARMACY NETWORK

A & P PHARMACY
 ALBERTSONS
 ARBOR DRUGS
 ARROW PRESC. CTR.
 AURORA
 BARTELL DRUG
 BI-LO PHARMACY
 BI-MART DRUG
 BIG BEAR
 BROOKS PHARMACY
 BROOKSHIRE
 BRUNO'S
 CARRS
 CITY MARKET
 COSTCO
 CUB PHARMACY
 CVS PHARMACY
 D & W PHARMACY
 DILLON PHARMACY
 DISCOUNT DRUG MART
 DOMINICK'S
 DRUG EMPORIUM
 DRUG FAIR
 DUANE READE
 EDGEHILL PHARMACY
 EDWARDS PHARMACY
 FAGAN PHARMACY
 FARMER JACK PHCY.
 FAY'S DRUG STORE
 FINAST PHARMACY
 FOOD TOWN PHCY.
 FRED MEYER
 FRED'S PHARMACY
 FRY'S FOOD & DRUG
 FURR'S PHARMACY

GENOVESE DRUG STORE
 GIANT EAGLE PHCY.
 GIANT FOOD INC.
 GIANT PHARMACY
 GRAND UNION PHCY.
 HANNAFORD DRUG
 HARCO DRUG
 HARVEST FOODS PHCY.
 H-E-B PHARMACY
 HI-SCHOOL PHARMACY
 HORIZON
 HY-VEE PHARMACY
 INTEGRATED PHARMACY
 K & B PHARMACY
 K-MART
 KARE DRUGS
 KASH & KARRY PHCY.
 KERR DRUG STORE
 KING SOOPERS
 KINNEY DRUGS
 KROGER DRUG
 LONG'S DRUG STORE
 MANAGED PHCY CARE
 MARC'S PHARMACY
 MAX/BROOKS PHCY.
 MEDICAP PHARMACY
 MEDIC DISC. DRUG
 MEDICINE SHOPPE
 MEDISTAT PHARMACY
 MEIJER PHARMACY
 OSCO DRUG
 PAMIDA PHARMACY
 PATHMARK PHARMACY
 PERRY DRUG STORE
 PRICE CHOPPER

PRICE COSTCO PHCY.
 PUBLIX PHARMACY
 RANDALL'S FOOD MKTS.
 RITE-AID PHARMACY
 RITZMAN PHARMACY
 SACK N' SAVE
 SAFEWAY PHARMACY
 SAV-ON DRUGS
 SAVE-MART PHARMACY
 SCHNUCK'S PHARMACY
 SHOP 'N SAVE DRUGS
 SHOPKO PHARMACY
 SMITH'S FOOD & DRUG
 SNYDER
 STOP & SHOP PHCY.
 SUPER D DRUGS
 TARGET PHARMACY
 TEXAS DRUG WRHS.
 TEXAS ONCOLOGY
 THRIFT DRUG
 THRIFTY/PAYLESS DRUG
 THRIFTY WHITE DRUG
 TIMES PHARMACY
 TOM THUMB/PAGE DRUG
 TOPS PHARMACY
 UNITED MANAGED CARE
 UNITED PHARMACY
 VON'S PHARMACY
 WAL-MART PHARMACY
 WALGREENS
 WEIS PHARMACY
 WELBY SUPER DRUG
 WINN DIXIE PHARMACY

Control Number: M2563

ACORD® GENERAL LIABILITY NOTICE OF OCCURRENCE/CLAIM

DATE (MM/DD/YY)

PRODUCER PHONE (952) 707-8200
 (A/C, No, Ext)
 FAX (952) 890-0535
 Kraus-Anderson Insurance
 420 Gateway Boulevard
 Burnsville, MN 55337-2790

NOTICE OF OCCURRENCE DATE OF OCCURRENCE AND TIME AM DATE OF CLAIM PREVIOUSLY REPORTED
 YES: NO
 NOTICE OF CLAIM
 EFFECTIVE DATE EXPIRATION DATE POLICY TYPE RETROACTIVE DATE
 04/01/2008 04/01/2009 OCCURRENCE CLAIMS MADE
 COMPANY MISCELLANEOUS INFO (Site & location code)
 Zurich American Ins Co
 CODE: 60092186 SUB CODE: POLICY NUMBER 5966467-00 REFERENCE NUMBER
 AGENCY CUSTOMER ID: 00005611

INSURED CONTACT CONTACT INSURED
 NAME AND ADDRESS NAME AND ADDRESS WHERE TO CONTACT
 Belair Builders, Inc.
 2200 Old Highway 8 NW
 New Brighton, MN 55112
 RESIDENCE PHONE (A/C, No) BUSINESS PHONE (A/C, No, Ext) RESIDENCE PHONE (A/C, No) BUSINESS PHONE (A/C, No, Ext)
 (651) 786-1300
 WHEN TO CONTACT

OCCURRENCE
 LOCATION OF OCCURRENCE (Include city & state) AUTHORITY CONTACTED
 DESCRIPTION OF OCCURRENCE (Use reverse side, if necessary)

POLICY INFORMATION
 COVERAGE PART OR FORMS (insert form #s and edition dates)
 GENERAL AGGREGATE PROD/COMP OF AGG PERS & ADV INJ EACH OCCURRENCE FIRE DAMAGE MEDICAL EXPENSE DEDUCTIBLE X PD
 2,000,000 2,000,000 1,000,000 1,000,000 300,000 10,000 50000 X BI
 UMBRELLA/ EXCESS UMBRELLA EXCESS CARRIER LIMITS: PER CLAIM PER OCCUR

TYPE OF LIABILITY
 PREMISES: INSURED IS OWNER TENANT OTHER TYPE OF PREMISES
 OWNER'S NAME & ADDRESS (if not insured) OWNERS PHONE (A/C, No, Ext)
 PRODUCTS: INSURED IS MANUFACTURER VENDOR OTHER TYPE OF PRODUCT
 MANUFACTURER'S NAME & ADDRESS (if not insured) MANUFACTURE PHONE (A/C, No, Ext)
 WHERE CAN PRODUCT BE SEEN?

OTHER LIABILITY INCLUDING COMPLETED OPERATIONS (Explain)

INJURED/PROPERTY DAMAGED
 NAME & ADDRESS (Injured/Owner) PHONE (A/C, No, Ext)
 AGE SEX OCCUPATION EMPLOYER'S NAME & ADDRESS PHONE (A/C, No, Ext)
 DESCRIBE INJURY WHERE TAKEN WHAT WAS INJURED DOING?
 FATALITY
 DESCRIBE PROPERTY (Type, model, etc) ESTIMATE AMOUNT WHERE CAN PROPERTY BE SEEN? WHEN CAN PROPERTY BE SEEN?

WITNESSES
 NAME & ADDRESS BUSINESS PHONE (A/C, No, Ext) RESIDENCE PHONE (A/C, No)

REMARKS
 REPORTED BY REPORTED TO SIGNATURE OF PRODUCER OR INSURED

ACORD® AUTOMOBILE LOSS NOTICE

DATE (MM/DD/YY)

PRODUCER PHONE (A/C, No, Ext): (952)707-8200 Kraus-Anderson Insurance 420 Gateway Boulevard Burnsville, MN 55337-2790		COMPANY Amer Guaranty & Liab Ins		MISCELLANEOUS INFO (Site & location code)	
AGENCY CUSTOMER ID: 00005611		POLICY NUMBER 5966468-00		REFERENCE NUMBER	
CODE: 60092186 SUB CODE:		EFFECTIVE DATE 04/01/2008		EXPIRATION DATE 04/01/2009	
		DATE OF ACCIDENT AND TIME		PREVIOUSLY REPORTED AM: YES: NO PM: YES: NO	

INSURED NAME AND ADDRESS Belair Builders, Inc. 2200 Old Highway 8 NW New Brighton, MN 55112		CONTACT NAME AND ADDRESS		CONTACT INSURED	
RESIDENCE PHONE (A/C, No)		BUSINESS PHONE (A/C, No, Ext) (651)786-1300		RESIDENCE PHONE (A/C, No)	
				BUSINESS PHONE (A/C, No, Ext)	

LOSS LOCATION OF ACCIDENT (Include city & state)		AUTHORITY CONTACTED: REPORT #		VIOLATIONS/CITATIONS	
DESCRIPTION OF ACCIDENT (Use reverse side, if necessary)					

POLICY INFORMATION					
BODILY INJURY (Per Person)		BODILY INJURY (Per Accident)		PROPERTY DAMAGE	
				SINGLE LIMIT 1,000,000	
				MEDICAL PAYMENT 20,000	
				OTC DEDUCTIBLE	
				OTHER COVERAGE & DEDUCTIBLES (UM, no-fault, towing, etc) PIP, UMCSL, UNCSL	
LOSS PAYEE				COLLISION DED	

UMBRELLA/ EXCESS		UMBRELLA		EXCESS CARRIER:		LIMITS:		PER CLAIM		PER OCCUR	
------------------	--	----------	--	-----------------	--	---------	--	-----------	--	-----------	--

INSURED VEHICLE															
VEH #		YEAR		MAKE:				BODY TYPE:		PLATE NUMBER		STATE			
				MODEL:				V.I.N.:							
OWNER'S NAME & ADDRESS						RESIDENCE PHONE (A/C, No):									
						BUSINESS PHONE (A/C, No, Ext):									
DRIVER'S NAME & ADDRESS						RESIDENCE PHONE (A/C, No):									
						BUSINESS PHONE (A/C, No, Ext):									
RELATION TO INSURED (Employee, family, etc.)			DATE OF BIRTH			DRIVER'S LICENSE NUMBER			STATE:			USED WITH PERMISSION? YES NO			
DESCRIBE DAMAGE				ESTIMATE AMOUNT				WHERE CAN VEHICLE BE SEEN?				WHEN CAN VEH BE SEEN? OTHER INSURANCE ON VEHICLE			

PROPERTY DAMAGED											
DESCRIBE PROPERTY (If auto, year, make, model, plate #)						OTHER VEH/PROP INS? YES NO		COMPANY OR AGENCY NAME:			
								POLICY #:			
OWNER'S NAME & ADDRESS						RESIDENCE PHONE (A/C, No):					
						BUSINESS PHONE (A/C, No, Ext):					
OTHER DRIVER'S NAME & ADDRESS (Check if same as owner)						RESIDENCE PHONE (A/C, No):					
						BUSINESS PHONE (A/C, No, Ext):					
DESCRIBE DAMAGE				ESTIMATE AMOUNT				WHERE CAN DAMAGE BE SEEN?			

INJURED													
NAME & ADDRESS				PHONE (A/C, No)				INS OTH: VEH VEH		AGE		EXTENT OF INJURY	

WITNESSES OR PASSENGERS													
NAME & ADDRESS				PHONE (A/C, No)				INS OTH: VEH VEH		OTHER (Specify)			

REMARKS (Include adjuster assigned)											
REPORTED BY				REPORTED TO				SIGNATURE OF PRODUCER OR INSURED			

BELAIR

EXCAVATING

Project Name:
 Address:
 Division:
 _____ Demolition
 _____ Environmental
 _____ Utility
 _____ Earthwork

Job # _____
 Personal Protective Equipment:
 Level D _____
 D Mod _____
 C _____ B _____ A _____

Analysis by:
Date:
Reviewed by:
Date:
Approved by:
Date:

Step #	Sequence of Basic Job Steps	Physical Requirements	Potential Hazards	Recommended Safe Job Procedures
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

TOOL BOX SAFETY MEETING

PROJECT NAME: _____ JOB # _____

DATE: _____ TIME: _____ SUPERINTENDENT _____

FOREMAN: _____

Attendees Signature

- | | |
|-----------|-----------|
| 1. _____ | 21. _____ |
| 2. _____ | 22. _____ |
| 3. _____ | 23. _____ |
| 4. _____ | 24. _____ |
| 5. _____ | 25. _____ |
| 6. _____ | 26. _____ |
| 7. _____ | 27. _____ |
| 8. _____ | 28. _____ |
| 9. _____ | 29. _____ |
| 10. _____ | 30. _____ |
| 11. _____ | 31. _____ |
| 12. _____ | 32. _____ |
| 13. _____ | 33. _____ |
| 14. _____ | 34. _____ |
| 15. _____ | 35. _____ |
| 16. _____ | 36. _____ |
| 17. _____ | 37. _____ |
| 18. _____ | 38. _____ |
| 19. _____ | 39. _____ |
| 20. _____ | 40. _____ |

Safety Items Discussed

Employee Suggestions

Safety Protection/Equipment Used

Superintendent Signature

Job # _____
Job Name _____
Date: _____
Time: _____

WEEKLY SAFETY MEETING AGENDA

- 1. Use weekly handout, discuss its topic, all people to sign in.
- 2. Discuss any injuries in the past week; remind employees to report all injuries.
- 3. Discuss emergency action and medical procedures.
- 4. Discuss any known safety violations.
- 5. Discuss operation of mobile earth moving equipment and train employees on precautions to take. Each employee working on the ground who is exposed to moving equipment must wear a high-visibility vest or garment. See standard for training information.
- 6. Discuss any near misses or unsafe conditions.
- 7. Discuss any new chemicals on site – material safety data sheets.
- 8. Discuss any possible asbestos or lead exposures.
- 9. Discuss any safety concerns on work for today, this week, or next month.
- 10. Ask if all people have received "Right-To-Know" training. Give specific training for your jobsite to employees new to jobsite.
- 11. Discuss harassment policy. Tell people to report to you if they encounter any harassment or report it to Belair Excavating, Vice President.
- 12. Open discussion.
- 13. Fax or mail to office:
 - a. this agenda
 - b. weekly safety topic sheet with signatures and/or Tool Box Safety Meeting sheet with signatures
 - c. Weekly safety check off list

Copies to: Jobsite Superintendent
Safety Director
Project Manager

WRITTEN SAFETY OFFENSE WARNING

Individual's name committing the offense _____

Date of the Offense: _____

Time of the Offense: _____

Job Name: _____

Job #: _____

Check which of the following that applies:

_____ First Safety Offense: Verbal Warning (Use this form to document)

_____ Second Safety Offense: A Written Warning (Use this form to document)

_____ Thirty Safety Offense: A Written Warning and Three Days off from
work with NO pay

_____ Fourth Safety Offense Termination

This listing of violations and penalties is intended to serve as a general guideline. Belair Excavating specifically reserves the right to modify the penalties or impose other forms of discipline, based upon the specific circumstances involved in each individual case, including termination on the first violation for particularly severe violations.

DESCRIPTION OF OFFENSE:

Name of Person Issuing Warning:

Signature of Person Issuing Warning:

Copy to: Employee; Superintendent; Safety Director; Employee File

BELAIR EXCAVATING

CITATION FORM

Colorado

Florida

Illinois

Minnesota

Date: _____

EMPLOYEE CITATION & CORRECTION FORM FOR TRUCKS, EQUIPMENT, AND EMPLOYEES
(Sub-Contractors and Vendors will pay any and all costs associated with violated incident)

EMPLOYEE:- _____	DATE OF INCIDENT: _____
LOCATION: _____	TIME OF INCIDENT: _____
SUPERVISOR: _____	TRUCK/EQUIP. NO: _____
JOB NO.: _____	PERSON CITING: _____

NOTE:

- First Offense - Warning
- Second Offense - One week suspension without pay
- Third Offense - Termination

(All citations valid two (2) years, unless extended below)

	Citation #	Citation #		
		1	2	3
1. Speeding				
2. Obscene Language				
3. Obscene Gestures				
4. Unauthorized Use Company Equip/Truck/Materials				
5. Unsafe Use of Equip/Trucks				
6. Unsafe Acts or Horseplay				
7. Expired Commercial License or Insurance Policy				
8. Preventable Accident with Truck or Equipment				
9. Operating Unsafe Truck or Equipment				
10. Damage Due to Negligence of Equipment/Trucks or Company Property				
11. Improper Equipment/Truck Warmup/Shutdown				
12. Overloaded Truck				
13. Improper Loading and/or Down Time				
14. Leaking Loads				
15. Dirty Equipment				
16. Failure to Wear Seat Belt, Hard Hat or P.P.E.				
17. Failure to Complete Accident/Safety Report				
18. Allowed Unauthorized Person to Ride				
19. Lack of Communication/Failure to Attend a Safety Mtg(s)				
20. Use of Non-Direct Route to Project				
21. Failure to Follow DOT Regulations				
22. Failure to Call Underground Locations				
23. Improper Maintenance of Equipment/Trucks				
24. Key Left In Equip./Trucks				
25. Failure to Report Unsafe Condition				
26. Failure to Follow Supervisor or Directors Orders				
27. Failure to Turn in Daily Tickets				
28. Failure to Turn in Time Card				
29. Failure to Properly Park Equip/Trucks				
30. Improper Equipment Security				
31. Improper Traffic Control				
32. Disrespectful Attitude/Language to Clients, Supervisors, or Co-Workers While on Job				
33. Any Use of Drugs or Alcohol While on Job				
34. Theft**				
35. Gross Negligence Causing Damage to Property or Injury to Person **				
36. Other - See Explanation Below **				
37. Non-compliance with Federal or State Guidelines				
38. Positive Drug & Alcohol Test				
39. A Preventable Underground or Overhead Hit				

** Stared Items are Cause for **IMMEDIATE** Termination

SPECIFIC VIOLATION(S): (By Number and Title) The term "gross" herein is defined as knowing better and causing an act to happen on purpose.
Negligence herein is defined as an act not done by plan.

CORRECTIVE STATEMENT BY EMPLOYEE: (Required)

CITATION EXTENSION BEYOND 2 YEARS (OR REDUCTION): NO (YES CHANGE TO ___ YEARS.)

EMPLOYEE:	DATE:
SUPERVISOR/DISPATCH:	DATE:
SAFETY OR HR DIRECTOR:	DATE:
LOCATES COORDINATOR:	DATE:

revised: 2024

BELAIR

EXCAVATING

Facility Audit Checklist

Date: ___/___/___
Time: ___:___ AM / PM

Auditor: _____
Colorado ___ Florida ___ Illinois ___ Minnesota ___

A) GROUNDS

1. Grass / Soil
2. Trees / Shrubs
3. Irrigation system
4. Landscaped areas free of weeds
5. Grounds free of debris

N/A	G	F	P

B) PARKING LOT

1. Blacktop condition
2. Striping / Curbs
3. Lighting / Signs
4. Sidewalks
5. Fence / Screening; plumb and in order
6. Rear of Building
7. Trash Containers/ dumpster area(s)

N/A	G	F	P

C) EXTERIOR OF BUILDING

1. Brick / Block / Paint
2. Pre-cast panels/ components
3. Windows, mirrors, glass
4. Loading Docks
5. Site lighting/ wall pacs
6. Bollards

N/A	G	F	P

D) ROOF

1. Flashing
2. Surface / HVAC, Mech, Elect curbs
3. Gutters/dwnspts cond. And flowing
4. Hatch/stairs cond. and clear access
5. Other

N/A	G	F	P

E) REST ROOMS

1. Dispensers
2. Floors / Partitions
3. Basins / Mirrors
4. Toilets / Urinals
5. Waste Receptacles

N/A	G	F	P

G) HALLWAYS/ ENTRIES

1. Walls / Ceilings
2. Carpet / Floors
3. Lighting
4. Waste Receptacles
5. Signage
6. Directory Board
7. Security System
8. Plants, wall hangings, pictures

N/A	G	F	P

H) OFFICES/ COMMONS

1. Workstations
2. Floor covering
3. Walls
4. Ceiling Tile / Lighting
5. Interior and exterior locksets
6. Other

N/A	G	F	P

I) UTILITY ROOM

1. Equipment
2. Organization and safe conds
3. Storage areas clean/ tidy

N/A	G	F	P

J) DIGI DOC/ IT ROOMS

1. Workstations
2. Equipment
3. Ventilation
4. Lighting
5. Protection in Place
6. Phones/ voice accessible
7. Housekeeping

N/A	G	F	P

K) HVAC/ Mech/ Elect Systems

1. Filters
2. Dampers marked
3. Water shut-offs accessible
4. Panels accessible and marked

N/A	G	F	P

DAILY EXCAVATING CHECK LIST

Any operation that creates any man-made cut, cavity, trench or depression formed by earth removal.

Date:	Job No.
-------	---------

Print Name of Competent Person

Signature of Competent Person

Digging/Excavation Location:

Name of Equipment Operator

Locate Resource Contacts:

Terry H. 651-248-0148
Tom L. 612-840-2436
Dan M. 651-248-027

CALL THESE PEOPLE IF YOU NEED HELP WITH LOCATES!!!

- | | Y | N | Digging/Excavation Check list |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have all locates been identified? If so, by whom? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have owner as-builts been reviewed for any existing live or abandoned utilities? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Utilities marked every 25' in soil and every 15' on hard surfaces? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Where is the colored plan located? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hand excavate to expose existing live utilities? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have soil conditions been identified as to classifications (i.e. type A, B, C soils)?
Soil Class |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hazardous atmospheres? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If necessary, has the air quality been checked in the excavation? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are protective systems in place? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spoil pile two feet back? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Means of access and egress? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | For the above soil classifications, has the proper benching/sloping been identified?
Recommended slope |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has pre-task planning been communicated with all personnel involved with digging operation? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ground personnel wearing high visibility vest? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Safe working clearances from overhead lines? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <u>Final Daily Inspection</u>
The area has been back-filled or properly barricaded to prevent personnel/pedestrian/ vehicles from entering the excavation? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Equipment Start Up Checklist Done? |

SOILS ANALYSIS CHECK LIST

This checklist must be completed when soil analysis is made to determine the soil type(s) present in the excavation. A separate analysis must be performed if the excavation (trench) is stretched over a distance where soil type changes.

SITE LOCATION:		
Date: _____	Time: _____	Competent Person: _____
Where was the sample taken from? _____		
Excavation Depth: _____	Excavation Width: _____	Excavation Length: _____

VISUAL TEST		
Particle Type:	Fine grained (cohesive) _____	Granular (sand/silt or gravel) _____
Water conditions:	Wet _____ Dry _____	Seeping Water _____
	Surface water present _____	Submerged _____
Previously disturbed soils:	Yes _____	No _____
Underground Utilities:	Yes: _____	No _____
If yes, what type? _____		
Layered soils? Note: The less stable layer controls soil type.	Yes _____	No _____
Layered soils dipping into excavation:	Yes _____	No _____ Unknown _____
Excavation exposed to vibrations:	Yes _____	No _____
If yes, from what? _____		
Crack like openings or spalling observed:	Yes _____	No _____
Conditions that may create a hazardous atmosphere:	Yes _____	No _____
If yes, identify condition and source: _____		
Surface encumbrances:	Yes _____ No _____	If yes, what type? _____
Work to be performed near public traffic:	Yes: _____	No: _____
Possible confined space exposure:	Yes _____	No _____

MANUAL TEST	
Plasticity:	Cohesive: _____ Non-cohesive _____
Strength:	Granular (crumbles easily) _____ Cohesive (broken with difficulty) _____
Wet shake: Water comes to surface (granular material) _____	
Surface remains dry (clay material) _____	

DRIVER'S VEHICLE INSPECTION REPORT

AS REQUIRED BY THE D.O.T. FEDERAL MOTOR CARRIER SAFETY REGULATIONS

CARRIER: _____

ADDRESS: _____

DATE: _____ TIME: _____ A.M. _____ P.M.

CHECK ANY DEFECTIVE ITEM AND GIVE DETAILS UNDER "REMARKS"

TRACTOR/
TRUCK NO. _____ ODOMETER READING _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Air Compressor | <input type="checkbox"/> Horn | <input type="checkbox"/> Suspension System |
| <input type="checkbox"/> Air Lines | <input type="checkbox"/> Lights | <input type="checkbox"/> Starter |
| <input type="checkbox"/> Battery | Head - Stop | <input type="checkbox"/> Steering |
| <input type="checkbox"/> Body | Tail - Dash | <input type="checkbox"/> Tachograph |
| <input type="checkbox"/> Brake Accessories | Turn Indicators | <input type="checkbox"/> Tires |
| <input type="checkbox"/> Brakes, Parking | <input type="checkbox"/> Mirrors | <input type="checkbox"/> Tire Chains |
| <input type="checkbox"/> Brakes, Service | <input type="checkbox"/> Muffler | <input type="checkbox"/> Transmission |
| <input type="checkbox"/> Clutch | <input type="checkbox"/> Oil Pressure | <input type="checkbox"/> Wheels and Rims |
| <input type="checkbox"/> Coupling Devices | <input type="checkbox"/> Radiator | <input type="checkbox"/> Windows |
| <input type="checkbox"/> Defroster/Heater | <input type="checkbox"/> Rear End | <input type="checkbox"/> Windshield Wipers |
| <input type="checkbox"/> Drive Line | <input type="checkbox"/> Reflectors | <input type="checkbox"/> Other |
| <input type="checkbox"/> Engine | <input type="checkbox"/> Safety Equipment | |
| <input type="checkbox"/> Exhaust | Fire Extinguisher | |
| <input type="checkbox"/> Fifth Wheel | Reflective Triangles | |
| <input type="checkbox"/> Frame and Assembly | Flags - Flares - Fusees | |
| <input type="checkbox"/> Front Axle | Spare Bulbs & Fuses | |
| <input type="checkbox"/> Fuel Tanks | Spare Seal Beam | |

TRAILER(S) NO.(S) _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Brake Connections | <input type="checkbox"/> Hitch | <input type="checkbox"/> Tarpaulin |
| <input type="checkbox"/> Brakes | <input type="checkbox"/> Landing Gear | <input type="checkbox"/> Tires |
| <input type="checkbox"/> Coupling Devices | <input type="checkbox"/> Lights - All | <input type="checkbox"/> Wheels and Rims |
| <input type="checkbox"/> Coupling (King) Pin | <input type="checkbox"/> Roof | <input type="checkbox"/> Other |
| <input type="checkbox"/> Doors | <input type="checkbox"/> Suspension System | |

Remarks: _____

CONDITION OF THE ABOVE VEHICLE IS SATISFACTORY

DRIVER'S SIGNATURE: _____

ABOVE DEFECTS CORRECTED

ABOVE DEFECTS NEED NOT BE CORRECTED FOR SAFE OPERATION OF VEHICLE

MECHANIC'S SIGNATURE: _____ DATE: _____

DRIVER'S SIGNATURE: _____ DATE: _____

ORIGINAL

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DRIVER'S VEHICLE INSPECTION REPORT

AS REQUIRED BY THE D.O.T. FEDERAL MOTOR CARRIER SAFETY REGULATIONS

CARRIER: _____

ADDRESS: _____

DATE: _____ TIME: _____ A.M. _____ P.M.

CHECK ANY DEFECTIVE ITEM AND GIVE DETAILS UNDER "REMARKS"

TRACTOR/
TRUCK NO. _____ ODOMETER READING _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Air Compressor | <input type="checkbox"/> Horn | <input type="checkbox"/> Suspension System |
| <input type="checkbox"/> Air Lines | <input type="checkbox"/> Lights | <input type="checkbox"/> Starter |
| <input type="checkbox"/> Battery | Head - Stop | <input type="checkbox"/> Steering |
| <input type="checkbox"/> Body | Tail - Dash | <input type="checkbox"/> Tachograph |
| <input type="checkbox"/> Brake Accessories | Turn Indicators | <input type="checkbox"/> Tires |
| <input type="checkbox"/> Brakes, Parking | <input type="checkbox"/> Mirrors | <input type="checkbox"/> Tire Chains |
| <input type="checkbox"/> Brakes, Service | <input type="checkbox"/> Muffler | <input type="checkbox"/> Transmission |
| <input type="checkbox"/> Clutch | <input type="checkbox"/> Oil Pressure | <input type="checkbox"/> Wheels and Rims |
| <input type="checkbox"/> Coupling Devices | <input type="checkbox"/> Radiator | <input type="checkbox"/> Windows |
| <input type="checkbox"/> Defroster/Heater | <input type="checkbox"/> Rear End | <input type="checkbox"/> Windshield Wipers |
| <input type="checkbox"/> Drive Line | <input type="checkbox"/> Reflectors | <input type="checkbox"/> Other |
| <input type="checkbox"/> Engine | <input type="checkbox"/> Safety Equipment | |
| <input type="checkbox"/> Exhaust | Fire Extinguisher | |
| <input type="checkbox"/> Fifth Wheel | Reflective Triangles | |
| <input type="checkbox"/> Frame and Assembly | Flags - Flares - Fusees | |
| <input type="checkbox"/> Front Axle | Spare Bulbs & Fuses | |
| <input type="checkbox"/> Fuel Tanks | Spare Seal Beam | |

TRAILER(S) NO.(S) _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Brake Connections | <input type="checkbox"/> Hitch | <input type="checkbox"/> Tarpaulin |
| <input type="checkbox"/> Brakes | <input type="checkbox"/> Landing Gear | <input type="checkbox"/> Tires |
| <input type="checkbox"/> Coupling Devices | <input type="checkbox"/> Lights - All | <input type="checkbox"/> Wheels and Rims |
| <input type="checkbox"/> Coupling (King) Pin | <input type="checkbox"/> Roof | <input type="checkbox"/> Other |
| <input type="checkbox"/> Doors | <input type="checkbox"/> Suspension System | |

Remarks: _____

CONDITION OF THE ABOVE VEHICLE IS SATISFACTORY

DRIVER'S SIGNATURE: _____

ABOVE DEFECTS CORRECTED

ABOVE DEFECTS NEED NOT BE CORRECTED FOR SAFE OPERATION OF VEHICLE

MECHANIC'S SIGNATURE: _____ DATE: _____

DRIVER'S SIGNATURE: _____ DATE: _____

VEHICLE COPY

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Belair Excavating
Employee Safety Manual Test
Test A

Name: _____

Date: _____

1. An employee has the “right to know” what chemical hazards are on the job site he or she is working on.
 T F
2. “AWAIR” is an expression used to remind a worker to wear his or her PPE at all times.
 T F
3. Belair’s State safety committee is made up of 4 office employees.
 T F
4. “Job Hazard Analysis” is a process to identify and create solutions for the control of hazards, before a project is started.
 T F
5. An accident report must be completed and turned in to the branch safety coordinator within 12 hours of an accident.
 T F
6. Belair has a random drug testing program in place.
 T F
7. You will be terminated after you are written up for more then 2 citations.
 T F
8. Belair does not address subcontractors in its employee safety manual.
 T F
9. Training is a major focus at Belair.
 T F

21. Forklift drivers need to be both trained and certified.

T F

22. Each State spells out training requirements for all equipment including Harley Davidson motorcycles.

T F

23. Belair does not have a shop and facility safety program in place.

T F

24. Utilities include high profile lines or visible pipes that are so far above the ground that they show in a high profile way.

T F

24. 85% of all accidents are caused by employees and 15% are machine failures.

T F

25. You "do not" have the authority to remove yourself from perceived danger.

T F

26. The Belair dig checklist needs to be completed daily before you start moving dirt.

T F

27. It is more important for our dig checklist to get fully completed, then it is to understand its content. The knowledge will come with time.

T F

28. All utilities need to be considered "live" until proven otherwise.

T F

29. We need to hand dig within 10' of a high profile facility.

T F

Belair Excavating
Employee Safety Manual Test
Test B

Name: _____

Date: _____

1. **Belair's State safety committee is made up of 4 office employees.**
 T F
2. **"AWAIR" is an expression used to remind a worker to wear his or her PPE at all times.**
 T F
3. **An employee has the "right to know" what chemical hazards are on the site he is working at.**
 T F
4. **"Job Hazard Analysis" is a process to identify and create solutions for hazard control, before a project is started.**
 T F
5. **An accident report must be completed and turned in to the branch safety coordinator within 12 hours of an accident.**
 T F
6. **Belair does not have a random drug testing program in place.** T F
7. **You will be terminated after you are written up for 2 or more citations.**
 T F
8. **Belair does not address subcontractors in its employee safety manual.**
 T F
9. **Safety training is a major focus at Belair.**
 T F

22. Each State has training requirements for all equipment including Harley Davidson motorcycles.
 T F
23. Belair does not have a shop and facility safety program in place.
 T F
24. Utilities include high profile lines or visible pipes that are so far above the ground they show in a high profile way.
 T F
25. 85% of all accidents are caused by employees and 15% are machine failures.
 T F
26. All utilities need to be considered "live" until proven otherwise.
 T F
27. The Belair dig checklist does not need to be completed daily, before you start moving dirt.
 T F
28. It is more important that our dig checklist gets fully completed, then to understand its content. Knowledge will come with time.
 T F
29. You "do not" have the authority to remove yourself from perceived danger.
 T F
30. We need to hand dig within 10' of a high profile facility.
 T F