

# CLS Health and Safety Program

## First Aid Risk Assessment

1. Date of Assessment \_\_\_\_\_ Location Name \_\_\_\_\_

Coordinator Name \_\_\_\_\_

2(a) Industry Hazard Rating by WorkSafe BC L  M  H

2(b) Job functions, work processes and tools. Typical of industry and CLS Yes  No

2(c) Types of injuries that can potentially occur. Typical of industry and CLS Yes  No

2(d) If answer to 2(b) and/or 2(c) is **NO**, please briefly give your reason for your answer.

2(b) Job functions, work processes and tools: Hazard L  M  H

\_\_\_\_\_

2(c) Types of Injuries: Hazard L  M  H

\_\_\_\_\_

Then: **Rating Adjustment**

Overall Location Hazard Rating: Hazard L  M  H

3(a) Surface travel time to hospital by car:  greater than 20 minutes  
 20 minutes or less

4(b) Highest number of employees on shift at any given time \_\_\_\_\_.

Overnight shift Yes  No  Awake  Asleep  Semi-Awake

Number of staff working O/N shift \_\_\_\_\_.

5(f) List any barriers to first aid:

\_\_\_\_\_

# **CLS Health and Safety Program**

## **First Aid Risk Assessment**

### **Assessment Results**

**5(a) Supplies/equipment/facilities required**

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**5(c) Number and level of First Aid attendants**

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**5(e) Transportation needs**

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### **Re-Assessment**

Date \_\_\_\_\_

**Change in condition at location:**

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**Consulted (CLS JOHS committee, employee representative, others):**

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Name \_\_\_\_\_ Signature \_\_\_\_\_

**If re-assessment required, send copy of entire form to CLS JOHS Committee.**