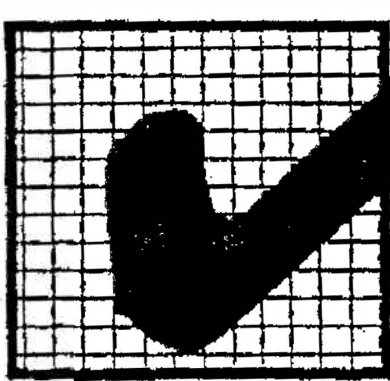

Workplace Injury & Illness Prevention Program



for
**non-high hazard
employers**



CS-1 revised October 2001 Cal/OSHA Consultation Service

State of California-Department of Industrial Relations- Division of Occupational Safety & Health

**MODEL
INJURY AND ILLNESS
PREVENTION PROGRAM
FOR
NON-HIGH HAZARD
EMPLOYERS**

ABOUT THIS MODEL PROGRAM

Every California employer must establish, implement and maintain a written Injury and Illness Prevention (IIP) Program and a copy must be maintained at each worksite or at a central worksite if the employer has non-fixed worksites. The requirements for establishing, implementing and maintaining an effective written Injury and Illness Prevention Program are contained in Title 8 of the California Code of Regulations, Section 3203 (T8 CCR 3203) and consist of the following eight elements:

- Responsibility
- Compliance
- Communication
- Hazard Assessment
- Accident/Exposure Investigation
- Hazard Correction
- Training and Instruction
- Recordkeeping

This model program has been prepared for use by employers in industries which have been determined by Cal/OSHA to be non-high hazard. You are not required to use this program. However, any employer in an industry which has been determined by Cal/OSHA as being non-high hazard who adopts, posts, and implements this model program in good faith is not subject to assessment of a civil penalty for a first violation of T8 CCR 3203.

Proper use of this model program requires the IIP Program administrator of your establishment to carefully review the requirements for each of the eight IIP Program elements found in this model program, fill in the appropriate blank spaces and check those items that are applicable to your workplace. The recordkeeping section requires that the IIP Program administrator select and implement the category appropriate for your establishment. Sample forms for hazard assessment and correction, accident/exposure investigation, and worker training and instruction are provided with this model program.

This model program must be maintained by the employer in order to be effective.

RESPONSIBILITY

The Injury and Illness Prevention (IIP) Program administrator,

Edward Knudson and/or designee.

Program Administrator

has the authority and the responsibility for implementing and maintaining this IIP Program for
Antelope Valley Community College District.

Establishment Name

Managers and supervisors are responsible for implementing and maintaining the IIP Program in their work areas and for answering worker questions about the IIP Program. A copy of this IIP Program is available from each manager and supervisor.

COMPLIANCE

All workers, including managers and supervisors, are responsible for complying with safe and healthful work practices. Our system of ensuring that all workers comply with these practices include one or more of the following checked practices:

- ☒ Informing workers of the provisions of our IIP Program.
- ☐ Evaluating the safety performance of all workers.
- ☐ Recognizing employees who perform safe and healthful work practices.
- ☐ Providing training to workers whose safety performance is deficient.
- ☐ Disciplining workers for failure to comply with safe and healthful work practices.

COMMUNICATION

All managers and supervisors are responsible for communicating with all workers about occupational safety and health in a form readily understandable by all workers. Our communication system encourages all workers to inform their managers and supervisors about workplace hazards without fear of reprisal.

Our communication system includes one or more of the following checked items:

- ☐ New worker orientation including a discussion of safety and health policies and procedures.
- ☐ Review of our IIP Program.
- ☐ Training programs.
- ☐ Regularly scheduled safety meetings.
- ☐ Posted or distributed safety information.
- ☒ A system for workers to anonymously inform management about workplace hazards.
- ☐ Our establishment has less than ten employees and communicates with and instructs employees orally about general safe work practices and hazards unique to each employee's job assignment.

HAZARD ASSESSMENT

Periodic inspections to identify and evaluate workplace hazards shall be performed by a competent observer in the following areas of our workplace:

Main Campus; Fox Field Site; Palmdale Center.

Periodic inspections are performed according to the following schedule:

1. § When we initially established our IIP Program;
2. § When new substances, processes, procedures or equipment which present potential new hazards are introduced into our workplace;
3. § When new, previously unidentified hazards are recognized;
4. § When occupational injuries and illnesses occur; and
5. § Whenever workplace conditions warrant an inspection.

ACCIDENT/EXPOSURE INVESTIGATIONS

Procedures for investigating workplace accidents and hazardous substance exposures include:

1. § Interviewing injured workers and witnesses;
2. § Examining the workplace for factors associated with the accident/exposure;
3. § Determining the cause of the accident/exposure;
4. § Taking corrective action to prevent the accident/exposure from reoccurring; and
5. § Recording the findings and actions taken.

HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices or procedures shall be corrected in a timely manner based on the severity of the hazards. Hazards shall be corrected according to the following procedures:

1. § When observed or discovered; and
2. § When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property, we will remove all exposed workers from the area except those necessary to correct the existing condition. Workers who are required to correct the hazardous condition shall be provided with the necessary protection.

TRAINING AND INSTRUCTION

All workers, including managers and supervisors, shall have training and instruction on general and job-specific safety and health practices. Training and instruction is provided:

1. When the IIP Program is first established;
2. To all new workers, except for construction workers who are provided training through a construction industry occupational safety and health training program approved by Cal/OSHA;
3. To all workers given new job assignments for which training has not previously provided;
4. Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard;
5. Whenever the employer is made aware of a new or previously unrecognized hazard;
6. To supervisors to familiarize them with the safety and health hazards to which workers under their immediate direction and control may be exposed; and
7. To all workers with respect to hazards specific to each employee's job assignment.

General workplace safety and health practices include, but are not limited to, the following:

1. Implementation and maintenance of the IIP Program.
2. Emergency action and fire prevention plan.
3. Provisions for medical services and first aid including emergency procedures.
4. Prevention of musculoskeletal disorders, including proper lifting techniques.
5. Proper housekeeping, such as keeping stairways and aisles clear, work areas neat and orderly, and promptly cleaning up spills.
6. Prohibiting horseplay, scuffling, or other acts that tend to adversely influence safety.
7. Proper storage to prevent stacking goods in an unstable manner and storing goods against doors, exits, fire extinguishing equipment and electrical panels.
8. Proper reporting of hazards and accidents to supervisors. Accidents are reported immediately or as soon as possible.
9. Hazard communication, including worker awareness or potential chemical hazards, and proper labeling of containers.
10. Proper storage and handling of toxic and hazardous substances including prohibiting eating or storing food and beverages in areas where they can become contaminated.

RECORDKEEPING

We have checked one of the following categories as our recordkeeping policy.

Category 1. Our establishment has twenty or more workers or has a workers' compensation experience modification rate of greater than 1.1 and is not on a designated low hazard industry list. We have taken the following steps to implement and maintain our IIP Program:

1. Records of hazard assessment inspections, including the person(s) conducting the inspection, the unsafe conditions and work practices that have been identified and the action taken to correct the identified unsafe conditions and work practices, are recorded on a hazard assessment and correction form; and
2. Documentation of safety and health training for each worker, including the worker's name or other identifier, training dates, type(s) of training, and training providers, are recorded on a worker training and instruction form.

Inspection records and training documentation will be maintained according to the following checked schedule:

For one year, except for training records of employees who have worked for less than one year which are provided to the employee upon termination of employment; or

Since we have less than ten workers, including managers and supervisors, we only maintain inspection records until the hazard is corrected and only maintain a log of instructions to workers with respect to worker job assignments when they are first hired or assigned new duties.

Category 2. Our establishment has fewer than twenty workers and is not on a designated high hazard industry list. We are also on a designated low hazard industry list or have a workers' compensation experience modification rate of 1.1 or less, and have taken the following steps to implement and maintain our IIP Program:

1. Records of hazard assessment inspections; and
2. Documentation of safety and health training for each worker.

Inspection records and training documentation will be maintained according to the following checked schedule:

For one year, except for training records of employees who have worked for less than one year which are provided to the employee upon termination of employment; or

Since we have less than ten workers, including managers and supervisors, we maintain inspection records only until the hazard is corrected and only maintain a log of instructions to workers with respect to worker job assignments when they are first hired or assigned new duties.

☒ Category 3. We are a local governmental entity (county, city, district, or and any public or quasi-public corporation or public agency) and we are not required to keep written records of the steps taken to implement and maintain our IIP Program.

ATTENDANCE SHEET

DATE:

TIME:

INSTRUCTOR:

COURSE:

LOCATION: ANTELOPE VALLEY COMMUNITY COLLEGE DISTRICT

SIGNATURE

PLEASE PRINT NAME

1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
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10.	_____	_____
11.	_____	_____
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13.	_____	_____
14.	_____	_____
15.	_____	_____

Keenan
Associates

License #0451271



ANTELOPE VALLEY COLLEGE
HUMAN RESOURCES & EMPLOYEE RELATIONS

**Supervisor's Report of Injury
Employee**

Please Print

Employee Name: _____ Department: _____

Job Title : _____ Date of Injury: ____ / ____ / ____

Time of Injury: _____ a.m. p.m. On premises? Yes ____ / No ____

Time employee began work on the day of the accident? _____ a.m. p.m.

What is employee's regular work schedule? (circle) M T W TH F Hours work per day? _____

Hours work per week? _____ Did supervisor witness the accident? Yes ____ / No ____

Name(s) of witnesses: _____

Location where accident occurred (if different than AVC, provide name of location & address:) _____

Description of how accident occurred: _____

Part of body affected (i.e. back, left wrist, right eye, etc.): _____

Did employee go to the doctor? Y / N Did an unsafe condition contribute to the accident: Y / N

Did the employee commit an unsafe act? Y / N If yes, explain: _____

How could the accident have been prevented? _____

Supervisor: _____

Date: ____ / ____ / ____

Title: _____

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ANTELOPE VALLEY COLLEGE

HUMAN RESOURCES & EMPLOYEE RELATIONS

**Supervisor's Report of Injury
Student Workers/Students in
Clinical Rotation**

Please Print

Student's Name: _____ Department: _____

Student's Title: _____ Date of Injury: ____ / ____ / ____

Time of Injury: _____ a.m. p.m. On premises? Yes ____ / No ____

Time student began work on the day of the accident? _____ a.m. p.m.

What is student's regular work schedule? (circle) M T W TH F Hours work per day? _____

Hours work per week? _____ Did supervisor witness the accident? Yes ____ / No ____

Name(s) of witnesses: _____

Location where accident occurred (if different than AVC, provide name of location & address:) _____

Description of how accident occurred: _____

Part of body affected (i.e. back, left wrist, right eye, etc.)? _____

Did the student go to the doctor? Y / N Did an unsafe condition contribute to the accident: Y / N

Did the student commit an unsafe act? Y / N If yes, explain: _____

How could the accident have been prevented? _____

Supervisor: _____

Date: ____ / ____ / ____

Title: _____

Additional comments:
Page 2.

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ANTELOPE VALLEY COLLEGE

Office of Human Resources & Employee Relations

EMPLOYEE STATEMENT OF ACCIDENT

Please check one:

- ☐ Administrator
☐ Faculty F/T
☐ Faculty P/T
☐ Classified
☐ CMS
☐ Registered
Volunteer

Please Print

Employee Name: _____ Date of Birth: ____ / ____ / ____

Address: _____ Phone #: () _____ - _____

City: _____ State: _____ Zip: _____ Date of Hire: ____ / ____ / ____

District extension: _____ Date of Accident: ____ / ____ / ____ Time of Accident: _____ a.m. p.m.

Job Title: _____ Department: _____

Location where accident occurred (if different than AVC, provide name of location & address:) _____

Witness(es) to the accident? Yes ____ No ____ if yes, name(s) _____

Description of how accident occurred: _____

Part of body affected (i.e. back, left wrist, right eye, etc.)? _____

Pre-designated physician on file in HR? Yes ____ No ____

Name, address, and phone number of pre-designated physician? _____

Time you began work on the day of the accident? _____ a.m. p.m.

What is your regular work schedule? (circle) M T W TH F Hours work per day: _____

Hours work per week: _____ Social Security #: _____

Did you miss at least one full day of work after the injury? Yes ____ No ____

Date last worked? ____ / ____ / ____ Date returned to work? ____ / ____ / ____

Still off work? Yes ____ No ____

Name of your immediate supervisor: _____

How could the accident have been prevented? _____

Employee signature: _____

Date: ____ / ____ / ____

Additional comments:
Page 2.

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ANTELOPE VALLEY COLLEGE

Office of Human Resources & Employee Relations

STUDENT STATEMENT OF ACCIDENT

Please Print

Student Name: _____ Date of Birth: ____ / ____ / ____

Address: _____ Phone #: () _____ - _____

City: _____ State: _____ Zip: _____ Date of Hire (student worker): ____ / ____ / ____

When did you start your clinical rotation (if applicable)? Date: ____ / ____ / ____

District extension: _____ Date of Accident: ____ / ____ / ____ Time of Accident: _____ a.m. p.m.

Job Title/Title at Clinic: _____ Department: _____

Location where accident occurred (if different than AVC, provide name of location & address:) _____

Witness(es) to the accident? Yes ____ No ____ if yes, name(s) _____

Description of how accident occurred: _____

Part of body affected (i.e. back, left wrist, right eye, etc.)? _____

If accident occurred at the clinic and you received treatment at the facility, enter name, address, and phone number of physician that treated you? _____

Time you began work/clinical rotation on the day of the accident? _____ a.m. p.m.

What is your regular work/clinic schedule? (circle) M T W TH F Hours work per day: _____

Hours work per week: _____ Social Security #: _____

Did you miss at least one full day of work or clinic time after the injury? Yes ____ / No ____

Date last worked/at clinical rotation? ____ / ____ / ____ Date returned to work/clinical rotation? ____ / ____ / ____

Still off work/clinical rotation? Yes ____ No ____

Name of your immediate supervisor: _____

How could the accident have been prevented? _____

Student signature: _____

Date: _____

Additional comments:
Page 2.



ANTELOPE VALLEY COLLEGE

Office of Human Resources & Employee Relations

INCIDENT REPORT

Please complete if not filing a workers' comp claim or not seeking treatment by a doctor

Please Print

Name: _____ Date of Birth: ____ / ____ / ____

Address: _____ Phone #: (____) ____ - ____

City: _____ State: _____ Zip: _____

District extension: _____ Date of Incident: ____ / ____ / ____ Time of Incident: _____ a.m. p.m.

Title: _____ Department: _____

Location where incident occurred (if different than AVC, provide name of location & address:) _____

Witness(es) to the incident? Yes ____ No ____ if yes, name(s) _____

Description of how incident occurred: _____

Part of body affected (i.e. back, left wrist, right eye, etc.)? _____

Time you began work on the day of the incident? _____ a.m. p.m.

Time you began clinical rotation on the day of the incident? _____ a.m. p.m.

What is your regular schedule? (circle) M T W TH F Hours per day: _____

Hours per week: _____ Social Security #: _____

Name of your immediate supervisor: _____

How could the incident have been prevented? _____

Signature of person who experienced incident: _____ Date: ____ / ____ / ____

Supervisor signature: _____ Date: ____ / ____ / ____

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