Employee Workplace Emergency Response Plan

Personal information on this form is collected under the legal authority of the Municipal Act, 2001, S. 270. The information is being collected to meet requirements under the AODA Employment Standards by creating a plan to be followed in the event of an emergency . If you have any questions about this collection, please contact the Human Resources Manager.

Upon request, this form will be made available in alternate accessible formats.

This Employee Workplace Emergency Response Plan was created on: (Date)

Employment Information

Name:

Facility:

Position:

Location within Facility:

Department:

Supervisor:

Nature of Disability:

Duration of Disability: ☐ Permanent ☐ Temporary

If temporary, identify the expected timeframe of this plan:

Required Assistive Aids (Circle) None | Cane | Crutches | Walker | Wheelchair | White Cane | Other (specify below)

Emergency Evacuation Assessment

Does the employee experience any of the following that could impede the ability to quickly evacuate the workplace?

Mobility limitations: interference with walking, using stairs, joint pain, use of mobility device (i.e., wheelchair, scooter, cane, crutches, walker, etc.)	☐ Yes	☐ No
Reduced energy; fatigue, tires easily	☐ Yes	☐ No
Respiratory impairment (due to temporary/permanent conditions or brought on by stress, exertion, exposure to dust, smoke, etc.)	☐ Yes	☐ No
Emotional, cognitive, or concentration difficulties; confusion or disorientation	☐ Yes	☐ No
Vision impairment, loss	☐ Yes	☐ No
Hearing impairment, loss	☐ Yes	☐ No
Require assistive technology or medication	☐ Yes	☐ No
Other (please specify)	☐ Yes	☐ No

Emergency Response Plan

Procedure for notifying the employee in the event of an emergency:

What is the employee's preferred method of communication in an emergency situation. List any assistive communication devices and/or accommodations required.

Primary accessible evacuation route/plan:

Indicate the procedure for getting the employee to the evacuation/exit point and any accommodations required.

Secondary accessible evacuation route/plan:

Indicate the procedure for getting the employee to the evacuation/exit point and any accommodations required.

Emergency Assistance Team

Does the employee request and consent to assistance from co-workers? ☐ Yes ☐ No

If yes, establish a team of co-workers who can assist the person with a disability during emergencies. Members of the Emergency Assistance Team should:

- Be physically and mentally capable of performing the task and not require assistance themselves
- Work close to the same hours and in the same area as the person they will be assisting

The employee creating this plan should be involved in selecting a minimum of 2 people who will become part of their Emergency Assistance Team.

Primary Assistant	**Alternate Assistant**

Name:		Name:	
Department:		Department:	
Contact Info:		Contact Info:	

Employee Personal Emergency Preparedness Kit

Does the employee require a Personal Emergency Preparedness Kit? (at the employee's discretion) ☐ Yes ☐ No

List contents (i.e., emergency supply of medication, food for specific dietary needs, personal assistive equipment and batteries, emergency health & contact information, etc.)

Acknowledgement & Release (Employee)

I acknowledge that the information contained on this form is accurate and hereby authorize the County of Middlesex to release applicable personal information contained within my Employee Workplace Emergency Response Plan to designated individuals within my Emergency Assistance Team and other emergency/first responders in the event of a workplace emergency situation.

Employee's Signature _____ Date _____

Acknowledgement of Review (Emergency Assistance Team Members)

I acknowledge that this Workplace Emergency Response Plan has been reviewed with me and I understand my role within the safe execution of this plan.

Primary Assistant

Name _____ Signature _____ Date _____

Alternate Assistant

Name _____ Signature _____ Date _____

Plan Prepared By:

Name: _____ **Position:** _____

Signature _____ Date _____

To End this Plan:

Indicate the reason(s) for ending this plan: (check all that apply)

- ☐ The temporary condition (requirement for the plan) has ended, and this plan is no longer required.
- ☐ The employee's condition has improved, changed, and this plan is no longer required.
- ☐ The employee has requested to end the plan.
- ☐ The employee is no longer employed with the County of Middlesex.
- ☐ The plan is no longer relevant and has been replaced by a new plan.
- ☐ Other (specify):

Employee Acknowledgement

I acknowledge that it is appropriate to end this plan for the above mentioned reason(s).

Employee's Signature	Date

Health and Safety

- ☐ This plan has been removed from the applicable facility Fire Plan.
- ☐ The Emergency Assistance Team have been notified of the end of this plan.

Name	Signature	Date