



8905 W. 187<sup>th</sup> Street, Suite 200  
Mokena, IL 60448  
[www.mocompany.com](http://www.mocompany.com)  
708.799.0028

July 15, 2025

Dear Employee:

In M & O Insulation /M & O Environmental Companies' Safety Program, we have a Substance Abuse Program that includes post-accident/incident drug/alcohol testing. Every employee involved in an accident that requires medical attention at a clinic or hospital will be required to submit to a drug/alcohol test. This will be done for all medical attention no matter what degree of injury. Our policy for those injured to go to a clinic or hospital will not change, but if an employee goes to a clinic or hospital, a drug/alcohol test will be performed. The contact for this test is Tom Castellarin.

Due to a regulation, all accidents/incidents where medical services are rendered by a provider outside the company, i.e. a doctor or nurse, must be reported not only to M & O, but also to the insurance company.

If an accident/incident does occur, M & O Insulation/M & O Environmental Companies will require four forms to be filled out, unless other forms have been approved or supplied by others, i.e. BP-Whiting.

There is a total of four (4) forms needed when an accident/incident occurs. They are:

**Form A:** Initial information that is needed at the Main office as soon as one can get it to the Main office.

**Form B:** Supervisor's Accident Investigation: Completed by the Foreman to explain what happened, the nature and location of the injury and what can be done to prevent a future similar incident.

**Form C:** Employee Injury/Accident Report: Completed by the employee/employees involved in an injury/accident, not by the Foreman. Here is where the employee explains what he/she thinks happened, and specifically states what was injured. If there are witnesses to the Incident, then this form should be used to record the Witness Statements. There are 2 copies: one for Injured Employee and the other highlighted for Witnesses.

**Form D:** This form must be completed by the injured, so M & O Insulation/M & O Environmental Companies can help facilitate treatment.

A reminder: most major accidents occur because attention was not paid to the small things that start a chain of events that could cause an accident, large or small.

**So Always Think Safety because Everybody Deserves a Future.  
Always Think Safety,**

Tom Castellarin  
Safety Coordinator

**M & O INSULATION CO.**

8905 W. 187<sup>th</sup> Street, Suite 200  
Mokena, IL 60448

**M & O ENVIRONMENTAL CO.**

TEL: 708-799-3850  
FAX: 708-799-8508

**INITIAL ACCIDENT/INCIDENT INFORMATION - FORM A****A. EMPLOYEE INFORMATION:**

NAME: \_\_\_\_\_ HOME PHONE NO.: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

\_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**B. JOBSITE INFORMATION: MOI      MOE (Circle one)**

JOB NAME: \_\_\_\_\_ JOB NUMBER: \_\_\_\_\_

JOB LOCATION and ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**C. ACCIDENT/INCIDENT INFORMATION:**

DATE OF INCIDENT: \_\_\_\_\_

TIME OF INCIDENT: \_\_\_\_\_

NATURE OF INJURY/ACCIDENT: \_\_\_\_\_

BODY PART AFFECTED: \_\_\_\_\_

WAS MEDICAL ATTENTION GIVEN: YES    NO    (Circle one)

WHERE WAS MEDICAL ATTENTION GIVEN: \_\_\_\_\_

BRIEF DESCRIPTION OF HOW INJURY/ACCIDENT HAPPENED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WILL INJURED MISS TIME: YES    NO    UNKNOWN      DATE BEGINNING: \_\_\_\_\_  
(Circle one)

**D. REPORTING OF ACCIDENT/INJURY**

ACCIDENT/INJURY REPORTED BY: \_\_\_\_\_

FOREMAN A/I REPORTED TO: \_\_\_\_\_

REPORTED TO OFFICE: YES    NO    TO WHOM: \_\_\_\_\_ TIME: \_\_\_\_\_  
(Circle one)

## **What is On-Site First Aid?**

1. Applying a band-aid to cuts no more severe than a paper cut.
2. Washing off and covering minor abrasions.
3. Applying ice to a bump caused by a low force impact.
4. Flushing the eye to remove a foreign object.
5. Hydration to alleviate a minor heat related illness.

All other treatment should be performed by a trained medical professional.

If an injury is a soft tissue injury, such as a back sprain, knee injury or a blow to the head, medical attention must be sought immediately.

**M & O Insulation Co. / M & O Environmental Co.**  
**Work-Related Injury and Illness Case Management Program**  
**SEPTEMBER 2022**

When an accident/incident occurs, the following will be performed:

- 1) The injured employee will notify his/her foreman immediately after the accident, not the next workday or next week.
- 2) The foreman will follow established accident treatment and notification procedures:
  - A) The Foreman will get treatment for the injured:
    - 1) at the site clinic (if available) for minor injuries.
    - 2) Escort injured employee to nearest clinic
    - 3) Calling 911 for extreme injuries, such as life or limb threatening.
  - B) The foreman will notify the Safety Department, the superintendent, if needed, the site and client by phone, with a follow-up written notification, if required.
  - C) Once Treatment is completed and foreman is back on site, the foreman will begin written notifications.
- 3) The foreman, with Field Safety, will perform an investigation to determine root cause and lessons learned.
  - A) Step 1 of an A/I investigations starts with Securing the Scene, especially for serious accidents.
  - B) Step 2 is to Gather Information. This step includes interviewing the participant and witnesses and getting signed written statements and if possible photographs, videotape or sketches of the scene.
  - C) Step 3 is to develop a Sequence of Events. This not only describes the A/I but includes events that led to the A/I and should be detailed enough to enable someone not familiar with the situation to envision the sequence of events.
  - D) The final step (4) is to Analyze the A/I. This is where the determination of the causes occurs to determine what can be done to prevent a future A/I. When conducting an interview with the participant, it is mandatory to get the exact nature of injury and have the participant write it on the injured employee form with signature as well as putting it in the written investigation. Every job is provided with the necessary documents that need to be completed by the injured employee, supervisor and witnesses.
  - E) M&O Companies requires four forms to be completed when an accident/incident occurs and submitted to the office as soon as possible to help avoid delay or denial of treatment.
    - 1) Form A: Initial information that is needed at the Main office as soon as you can get it to the Main office.
    - 2) Form B: Supervisor's Accident Investigation: To be completed by the Foreman to explain what happened, the nature and location of the injury and what can be done to prevent a future incident.
    - 3) Form C: Employee Injury/Accident Report: To be completed by the employee/employees involved in the injury/accident, not by the Foreman. Here is where the employee explains what he/she thinks happened, and specifically states what was injured. If there are witnesses to the A/I, then this form should be used to record the Witness Statements.
    - 4) Form D: Medical Authorization Form: This needs to be completed by injured, so M&O Companies can help facilitate treatment. This form must be completed to insure payment of invoices.
- 4) If an accident/incident does occur, every employee involved in the accident that requires medical attention at a clinic or hospital will be required to submit to a drug/alcohol test. This will be done for all medical attention no matter what degree of injury. The contacts for this test are Tom Castellarin and Mary Castellarin.
- 5) Treatment of the injured will be directed by the insurance company. At no time will case management of an injured employee be done by job site personnel.
- 6) The injured employee will be monitored to determine if and when release to work is feasible. To return to work the employee must obtain a Work Release from the doctor. The doctor must have knowledge of the type of work being performed by the employee in a normal work week and if there is work available meeting any restrictions made by the doctor in written form. When a written full duty release is obtained, employee will be allowed to work without any restrictions. Case management is dependent on full communication between office, field, injured employee, doctor and insurance company. It is M & O's policy to get the injured employee treated and healthy so he/she can go back to work without complications, as quickly as possible.

## **Accident/Incident Happens**

### **On Site First Aid Treatable: Is injury a minor cut or bruise?**

#### **No**

Take to Clinic or Nearest Hospital  
  
Call Superintendent  
Complete Initial form for Office  
Perform Investigation  
Complete Remaining Forms

#### **Yes**

Treat injury, clean injury and apply band-aid adhesive or apply ice  
Call Superintendent  
Complete Initial form for office  
Perform Investigation  
Complete remaining forms

### **Did Accident occur do to being struck by falling object?**

#### **Yes**

Take to Clinic or Nearest Hospital  
Call Superintendent  
Complete Initial form for Office  
Perform Investigation  
Complete Remaining Forms

#### **No**

Treat injury  
Call Superintendent  
Complete Initial form for office  
Perform Investigation  
Complete remaining forms

### **Is Injury to soft tissue (i.e. Back or Knee)?**

#### **Yes**

Take to Clinic or Nearest Hospital  
Call Superintendent  
Complete Initial form for Office  
Perform Investigation  
Complete Remaining Forms

#### **No**

Treat injury  
Call Superintendent  
Complete Initial form for office  
Perform Investigation  
Complete remaining forms

**M & O INSULATION/M & O ENVIRONMENTAL  
ACCIDENT INVESTIGATION FORM B**

**WHEN:**

Date and Time of Accident: \_\_\_\_\_

Accident Site: \_\_\_\_\_

Was the report to Supervisor or First Aid Delayed: Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, why \_\_\_\_\_

**WHO:**

Injured Person: \_\_\_\_\_ Occupation: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**INJURY or Loss:**

Nature/Extent of Injuries or Property Damage: \_\_\_\_\_

**WHERE:**

Exact Area in Facility Where Accident Occurred: \_\_\_\_\_

**WHAT/HOW:**

Was employee doing something other than required duties at time of Accident: Yes: \_\_\_\_\_ No \_\_\_\_\_

If yes, What and Why: \_\_\_\_\_

Description of Accident (What was the Injured Doing, How was He/She doing it, and what tools, structures or equipment were involved): \_\_\_\_\_

**WHY:**

Did injury occur? \_\_\_\_\_

**PREVENTION:** What should be done and by whom to prevent recurrence of this type of Accident?

\_\_\_\_\_

\_\_\_\_\_

What action are you taking to see that this is done? \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Supervisor's Signature: \_\_\_\_\_

Date of Report: \_\_\_\_\_

# HELPFUL QUESTIONS

The following questions may assist in determining the facts:

**1. WHO**

- was injured?
- saw the accident?
- was working with the injured person?
- had instructed and/or assigned the job to the injured person?
- else was involved?
- has information on events prior to the accident?

**2. WHAT**

- is the injury?
- is the damage or loss?
- was the injured person doing?
- had the injured person been instructed to do?
- tools were being used?
- machinery/plant/equipment was in use?
- previous similar accidents or near misses have occurred?
- action had been taken to prevent recurrence?
- did the injured person and any witnesses see?
- safety rules were violated?
- safe systems of work, permits to work, isolation procedures were there?
- training had been given?

**3. WHEN**

- did the accident occur?
- did the damage become evident?
- did the injured person start the job?
- was an explanation of the hazards given?
- did the supervisor last see the injured person?
- was something observed to be wrong?

**4. WHERE**

- did the accident occur?
- did the damage occur?
- was the supervisor at the time?
- were the witnesses at the time?

**5. WHY**

- did the injury occur?
- did communication fail?
- was training not given?
- were the unsafe conditions permitted?
- was the hazard not evaluated?
- was personal protective equipment not provided?
- was protective equipment not used?
- was there no safe system of work, permit to work or isolation procedure operating?
- were specific safety instructions not given?
- was the supervisor not consulted when things started to go wrong?

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## **EMPLOYEE INJURY/ACCIDENT REPORT - FORM C**

THIS FORM TO BE COMPLETED BY INDIVIDUAL/INDIVIDUALS INVOLVED IN ACCIDENT OR WITNESSES TO THE ACCIDENT (Witnesses must complete a minimum of items marked by asterisk \*).

**A. EMPLOYEE INFORMATION:** **INJURED** WITNESS (Circle One)

NAME\*: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**B. JOBSITE INFORMATION\*: MOI MOE** (Circle One)

JOB NAME\*: \_\_\_\_\_ JOB NUMBER\*: \_\_\_\_\_

JOB LOCATION and ADDRESS\*: \_\_\_\_\_

**C. INJURY/ACCIDENT INFORMATION:**

DATE OF INCIDENT\*: \_\_\_\_\_

TIME OF INCIDENT\*: \_\_\_\_\_

TYPE OF INJURY/ACCIDENT\*: \_\_\_\_\_

WITNESSES TO INJURY/ACCIDENT\*: \_\_\_\_\_

WAS MEDICAL ATTENTION GIVEN: YES NO (Circle One) IF YES: WHERE: \_\_\_\_\_

DESCRIPTION OF MEDICAL ATTENTION GIVEN: \_\_\_\_\_

NATURE OF INJURY/ACCIDENT: \_\_\_\_\_

BODY PART AFFECTED: \_\_\_\_\_

DESCRIPTION OF HOW INJURY/ACCIDENT HAPPENED\*: \_\_\_\_\_

INJURED/WITNESS SIGNATURE\*: \_\_\_\_\_ DATE OF REPORT\*: \_\_\_\_\_

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**THIS FORM TO BE COMPLETED BY INDIVIDUAL/INDIVIDUALS INVOLVED IN ACCIDENT OR WITNESSES TO THE ACCIDENT (Witnesses must complete a minimum of items marked by asterisk \*).**

**A. EMPLOYEE INFORMATION: INJURED WITNESS (Circle One)**

**NAME\*:** \_\_\_\_\_ **PHONE NO.\*:** \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**B. JOBSITE INFORMATION\*: MOI MOE (Circle One)**

**JOB NAME\*:** \_\_\_\_\_ **JOB NUMBER\*:** \_\_\_\_\_

**JOB LOCATION and ADDRESS\*:** \_\_\_\_\_

**C. INJURY/ACCIDENT INFORMATION:**

**DATE OF INCIDENT\*:** \_\_\_\_\_

**TIME OF INCIDENT\*:** \_\_\_\_\_

**TYPE OF INJURY/ACCIDENT\*:** \_\_\_\_\_

**WITNESSES TO INJURY/ACCIDENT\*:** \_\_\_\_\_

WAS MEDICAL ATTENTION GIVEN: YES NO (Circle One) IF YES: WHERE: \_\_\_\_\_

DESCRIPTION OF MEDICAL ATTENTION GIVEN: \_\_\_\_\_

NATURE OF INJURY/ACCIDENT: \_\_\_\_\_

BODY PART AFFECTED: \_\_\_\_\_

**DESCRIPTION OF HOW INJURY/ACCIDENT HAPPENED\*:** \_\_\_\_\_

**INJURED/WITNESS SIGNATURE\*:** \_\_\_\_\_ **DATE OF REPORT\*:** \_\_\_\_\_

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Fax: 708-799-8508

**MEDICAL AUTHORIZATION - FORM D**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SS #: \_\_\_\_\_

DOB: \_\_\_\_\_

You are hereby authorized to release to:

**M & O INSULATION CO.**8905 W. 187<sup>th</sup> St. Suite 200

Mokena, IL 60448

Fax # 708-799-8508

**OR****M & O ENVIRONMENTAL CO.**8905 W. 187<sup>th</sup> St. Suite 200

Mokena, IL 60448

Fax # 708-799-8508

Or any representative acting on its behalf and to permit them to examine and/or copy:

Any and all hospital records, medical records, psychological records, x-ray films and their reports, any type of diagnostic test and their reports, all test of any type and character and their reports, statements of charges and any and all records of medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense in your possession or control pertaining to the undersigned. (Illinois Mental Health and Developmental Disabilities Confidentiality Act – REF: 740 ILCS 110/1 et seq; and, Illinois Workers Compensation Act 820 ILCS305/8(a)).

You are also authorized to discuss with them my injuries, physical condition, treatment and care and to furnish them with a written report regarding same.

The purpose for releasing this information is:

- A. To facilitate the evaluation of my claim for Workers' compensation benefits. (REF: 50IL Admin Code, Ch II sec 7110.70).
- B. To permit said disclosed information to be admitted into evidence at a hearing on my claim for said benefits pursuant to the appropriate rules of practice before the Illinois Industrial Commission.

I understand this authorization is voluntary and made to confirm my decision to disclose my medical information. I understand that, if the persons or organizations I authorized above to receive and/or use the protected health information (PHI) described above are subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

A photo-static copy of this authorization shall be as valid as the original. This authorization is valid for the duration of the claim.

You are hereby released from any and all liability or responsibility, which could or might result because of the disclosure of any information pursuant to this authorization.

\_\_\_\_\_  
Date\_\_\_\_\_  
Signature\_\_\_\_\_  
Witness\_\_\_\_\_  
Printed Name