



## Emergency Response Plan

### Company Information

Company Name: \_\_\_\_\_

Location: \_\_\_\_\_

### Emergency Response Coordinator

#### Primary Contact

Name: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_

Secondary Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

#### Secondary Contact

Name: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_

Secondary Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

### Emergency Contact Numbers

Fire Station: \_\_\_\_\_

Ambulance: \_\_\_\_\_

Police: \_\_\_\_\_

Nearest Hospital(s) or Clinic(s): \_\_\_\_\_

# Jacobson & Greiner

Group of Companies



## Potential Emergencies

The following potential emergencies have been identified in hazard assessments:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Location of Emergency Equipment

Fire alarm: \_\_\_\_\_

Fire Extinguisher: \_\_\_\_\_

Personal Protective Equipment: \_\_\_\_\_

Emergency Communication Equipment: \_\_\_\_\_

## First Aid

Type of first aid kit: \_\_\_\_\_

Location of first aid kit: \_\_\_\_\_

Other supplies: \_\_\_\_\_

Transportation for ill/injured employees will be: \_\_\_\_\_

## First Aid Attendant (employee with first aid training)

Name: \_\_\_\_\_

Location: \_\_\_\_\_

Shift/hours of work: \_\_\_\_\_

Has this plan been communicated and reviewed to employees?      Yes      Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of individual conducting review:

\_\_\_\_\_  
Date: