

April 6, 2021

Ms. Tanowa Troupe, Secretary
Ohio Power Siting Board
Docketing Division
180 East Broad Street, 11th Floor
Columbus, Ohio 43215-3797

Re: Case No. 20-1605-EL-BGN - In the Matter of the Application of Birch Solar 1, LLC for a Certificate of Environmental Compatibility and Public Need to Construct a Solar-Powered Electric Generation Facility in Allen and Auglaize Counties, Ohio.

Response to Second Data Request from Staff of the Ohio Power Siting Board

Dear Ms. Troupe:

Attached please find Birch Solar 1, LLC's ("Applicant") Response to the Second Data Request from the staff of the Ohio Power Siting Board ("OPSB Staff"). The Applicant provided this response to OPSB Staff on April 6, 2021.

We are available, at your convenience, to answer any questions you may have.

Respectfully submitted,

/s/ Christine M.T. Pirik

Christine M.T. Pirik (0029759)

(Counsel of Record)

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Randall Schumacher
Jon Pawley

Ms. Tanowa Troupe
Birch Solar 1, LLC
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CERTIFICATE OF SERVICE

The Ohio Power Siting Board's e-filing system will electronically serve notice of the filing of this document on the parties referenced in the service list of the docket card who have electronically subscribed to these cases. In addition, the undersigned certifies that a copy of the foregoing document is also being served upon the persons below this 6th day of April, 2021.

/s/ Christine M.T. Pirik

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Administrative Law Judge:

michael.williams@puco.ohio.gov

4837-0518-9348 v1 [92234-1]

**BEFORE
THE OHIO POWER SITING BOARD**

In the Matter of the Application of Birch Solar 1,)
LLC for a Certificate of Environmental)
Compatibility and Public Need to Construct a Solar-) Case No: 20-1605-EL-BGN
Powered Electric Generation Facility in Allen and)
Auglaize Counties, Ohio.)

BIRCH SOLAR 1, LLC 'S
RESPONSE TO THE SECOND DATA REQUEST
FROM THE STAFF OF THE OHIO POWER SITING BOARD

On February 12, 2021, as supplemented on March 25 and 31, 2021, and April 5, 2021, Birch Solar 1, LLC (“Applicant”) filed an application (“Application”) with the Ohio Power Siting Board (“OPSB”) proposing to construct a solar-powered electric generation facility in Allen and Auglaize Counties, Ohio.

On March 22, 2021, the Staff of the OPSB (“OPSB Staff”) provided the Applicant with OPSB Staff’s Second Data Request. Now comes the Applicant providing the following response to the Second Data Request from the OPSB Staff.

Project Description

1. **Confirm that Birch Solar I, LLC is not proposing to use the concentrating solar power technology in the project area.**

Response: The Project will use photovoltaic (“PV”) solar panels to produce electricity. The Project will not use concentrated solar power (“CSP”) technology. Apart from utilizing the sun’s energy, PV and CSP are completely different technologies. CSP uses mirrors to reflect and concentrate sunlight in order to heat a liquid that in turn drives steam turbines or engines in order to generate electricity.

2. **Is the photograph in Figure 9 of Exhibit U, Visual Resources Technical Report, a depiction of the cedar farm fencing described on page 8 of the Application? If not, please provide an example photo of cedar farm fencing.**

Response: Yes, the photosimulation in Figure 9 of Application Exhibit U includes the cedar farm fencing that is proposed for use as part of the Project and is referenced on page 8 of the Application Narrative.

Decommissioning

3. **Will the updated decommissioning plan be provided to Staff at least 30 days prior any preconstruction conference?**

Response: Yes, the Applicant will provide the updated Decommissioning Plan to Staff at least 30 days prior to the preconstruction conference.

4. **How often will Birch Solar I, LLC periodically update the decommissioning plan and decommissioning cost estimates?**

Response: The Applicant will update the Decommissioning Plan and decommissioning cost estimates every five years after the start of Project operation.

Figure 03-1

5. **Regarding Figure 03-1, what is the distance between the existing transmission line and the nearest proposed solar panel and inverter.**

Response: From the existing transmission line and switchyard, the nearest solar panel is approximately 110 feet away and the nearest inverter is approximately 360 feet.

6. **Does Birch Solar I, LLC anticipate any electrical interference from the existing transmission line to the solar panels, inverters, and electrical collection system?**

Response: No, the Applicant does not anticipate any electrical interference from the existing transmission line to the solar panels, inverters, and electrical collection system. Construction setbacks, as outlined below, will be put in place around existing transmission lines and transmission line setbacks are in place for modules and inverters as part of the current site design.

7. **Is there an applicable national electrical code that Birch Solar I, LLC would be required to conform to regarding the distance or buffer between the existing transmission line and the solar panels, inverters, and electrical collection system?**

Response: Yes, there are applicable National Electric Code (“NEC”) requirements and the Project will comply with those requirements.

Existing Transmission Line in Project Area

8. **Describe standard work procedures and safety precautions that will be implemented while working near the existing transmission line.**

Response: The Project will implement the Applicant's best management practice of 100-foot setbacks on either side of an existing transmission line. Additionally, "goalposts" are constructed for construction equipment operating adjacent to the transmission lines to ensure no overhead strikes. The goalpost markers are placed before and after the overhead power lines at both sides of both ends of the affected right-of-way at a minimum of 20 feet from directly below the power line. The picture below illustrates how the goalposts are used. The goalpost markers will be removed following construction of the Project.



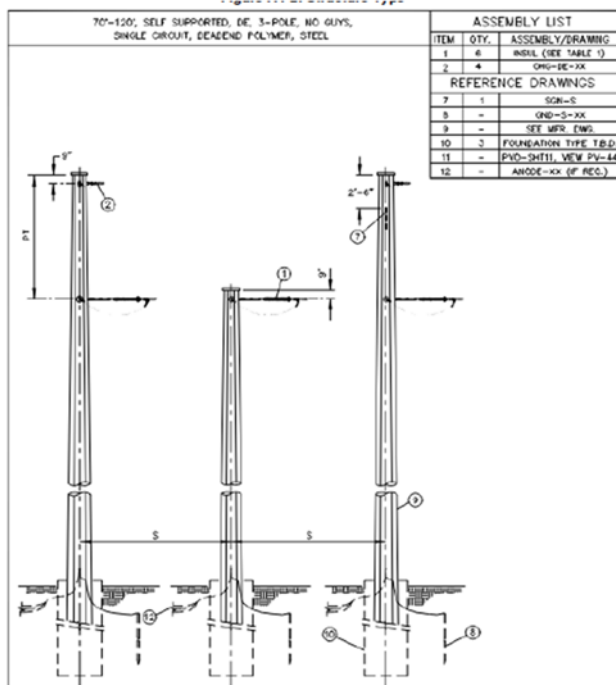
Generation Interconnection (gen-tie) Line

9. **Update Figure 03-2 (Project Site Layout Map) and other relevant facility mapping to reflect the location of the 345 kV gen tie line and provide associated shapefiles.**

Response: Figure 03-2 has been updated to reflect the preliminary location of the 345 kV gen-tie line and is provided as Attachment 1 to this data response request. The shapefile for this feature has been provided to OPSB Staff. Figure 03-2 in Attachment 1 supersedes and replaces Figure 03-2 that was filed with the Application on February 12, 2021.

10. Provide the following information for the gen tie line referenced on page 14 of the Application:

- a. **Tower designs, pole structures, conductor size and number per phase, and insulator arrangement.** The Project is currently planning a cut-in power design comprised of two steel 3-pole, self-supporting, dead-end structures on drilled shaft foundations with Aluminum Conductor Steel-Reinforced (“ACSR”) cable “Drake” conductors. Seven #7 Alumoweld shield wires will be installed on the tap spans. Below is a sample structure design.



- b. **Base and foundation design.** The foundation will consist of a drilled shaft, which is a cylindrical excavation from which all of the soil and rock has been removed.
- c. **Cable type and size, where underground.** There will be no underground cable associated with the gen-tie line.
- d. **Other major equipment or special structures.** There are no other special structures maybe included; however, a high voltage circuit breaker is being evaluated.

11. **How many support structures does Birch Solar I, LLC anticipate will be constructed to support the gen tie line?**

Response: Between 2 and 4 structures will be constructed to support the gen-tie line.

12. **Is the gen tie line within one hundred feet of an occupied residence or institution? If yes, please provide the calculated electric and magnetic field strength levels at one meter above ground, under the conductors and at the edge of the right-of-way for (i) Winter normal conductor rating, (ii) Emergency line loading, and (iii) Normal maximum loading.**

Response: The gen-tie line is not within 100 feet of any occupied residence or institution.

13. **Confirm that the project substation will be designed according to regional utility practices, PJM Standards, ReliabilityFirst Organization Standards, the National Electrical Code (NEC), and/or the Rural Utility Service Code.**

Response: The substation will be designed according to all regional utility practices including PJM Interconnection LLC Standards, ReliabilityFirst Organization Standards, the NEC, and the Rural Utility Service Code.

Aviation

14. **Explain what the tallest structure would be and list its height for the solar farm, gen tie, and project substation?**

Response: As stated in the Application, the height of the solar modules will be a maximum of 10 feet tall and are the tallest structures associated with the solar farm. The gen-tie line poles will have a height of between 70 and 120 feet, while the tallest component at the Project substation will be the lightning mast with a height of between 70 and 120 feet.

Wind Velocity

15. **Do the trackers under consideration have a stow mode?**

Response: Yes, the trackers under consideration do have a stow mode.

Emergency Response Plan

16. **Will the emergency response plan for the project referenced on page 44 of the Application be provided to OPSB Staff prior to the preconstruction conference?**

Response: Yes, the Applicant will provide the Emergency Response Plan to the OPSB Staff at least 30 days prior to the preconstruction conference.

17. **Provide the current draft emergency response plan or an example emergency response plan.**

Response: Emergency Response Plans are specific to each site and the Engineering, Procurement and Construction (“EPC”) firm selected. EPC contractors are not selected until after an OPSB certificate is issued and before construction. Therefore, for the Birch Solar Project, the EPC contractor has not yet been selected. However, the Applicant has strict requirements which are imposed on our EPC constructors. A sample of the Emergency Response Plan for another project developed by the Applicant is included as Attachment 2, included in this sample is a sample of an Emergency Action Map. Since this is a sample, the actual names and contacts have not been included in Attachment 2.

Water Conservation Practice

18. **For the O&M building, would Birch Solar I, LLC install modern, efficient water fixtures for all water usage, and regular maintenance to keep water fixtures in proper working order?**

Response: Yes, the Operations and Maintenance (“O&M”) Building would install modern, efficient water fixtures based on local plumbing codes. Maintenance efforts at the Project would include regular maintenance of these fixtures.

19. **For the O&M building, does Birch Solar I, LLC anticipate the usage to be equivalent to that of a small office building?**

Response: Yes, the O&M Building would be used for general office use, employee space and equipment storage and would have water use similar to a small office building.

20. **On pages 10 and 40 of the Application, Birch Solar I, LLC anticipates occasional cleaning of the solar panels with water dependent on weather or site conditions. How often would these be cleaned on an annual basis?**

Response: The Project anticipates that cleaning may be needed throughout the life of the project. This is dependent on natural precipitation and often is not required throughout the year or the life of the project. While the Project estimates that this could be done in dry years, most years cleaning will not be needed.

21. **What is the approximate total annual volume of water that would be required to clean solar farm equipment?**

Response: If cleaning is needed, which is rare, approximately 3 gallons of water is used per module.

Aesthetics

22. **Provide a large-scale aerial map that depicts all inhabited residential dwellings adjacent to the project area that have a direct, unobstructed line-of-sight view to the project boundaries. Identify on the map which receptors are participating and non-participating, as well as any nearby roads and highways.**

Response: To identify the residential dwellings adjacent to the Project Area where the solar modules will be visible, a Geographic Information Systems (“GIS”) raster model viewshed analysis was created to determine the Project’s theoretical visibility in its surrounding vicinity based on topography, existing vegetation, and the dimension of the Project components. Inputs to the model included a digital elevation model to reflect the topography. To determine the location and height of vegetation, the U.S. Department of Agriculture and U.S. Department of the Interior’s LANDFIRE “Existing Vegetation Height” data was utilized (2021). The assumed panel height included in the model is consistent with the Application, with a maximum solar module height of 10 feet. As a conservative estimate, to capture the view from each residence, it was assumed that the home was one story with a height of approximately 12 feet and that the viewer is on the roof affording a 360-degree view.

A total of 101 residences were identified on parcels adjacent to the Project Area, of these, the model predicts 69 residences will have some view of the Project and 32 will have no visibility of the Project. The figure provided in Attachment 3 depicts the location of the residences relative to the Project and existing vegetation and whether the Project will be visible or not visible and the participation status of the residence.

While 69 residences are identified as having at least some visibility of the solar modules, few have completely unobstructed line-of-sight views of the Project. Additionally, the Applicant has committed to implementing vegetative screening in strategic locations along the perimeter of the Project to further screen the Project in views from the nearby residences and roadways. The location of the proposed vegetative screening is also depicted in Attachment 3. The Applicant proposes to plant arbovitae trees (*Thuja* spp.) or

a similar evergreen tree species. The trees will be 6 feet tall at the time of planting and are anticipated to grow to a full height of approximately 8 feet. The trees will be spaced 6 feet on center. In addition to the vegetative screening, the Applicant will utilize cedar post farm fencing around the external facing areas of the Project rather than the originally proposed chain link fencing. This farm fencing will better blend into the existing agricultural landscape. The photosimulation below shows the vegetative screening proposed, as well as the cedar post farm fencing. The fencing and vegetation is also set back 300 feet from Breese Road, which will allow farming to continue between the road and the Project, creating an additional vegetative buffer during the growing season.



Respectfully submitted,

/s/ Christine M.T. Pirik

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(Counsel of Record)

Terrence O'Donnell (0074213)

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Columbus, Ohio 43215

Phone: (614) 591-5461

Email: cpirik@dickinsonwright.com

todonnell@dickinsonwright.com

Attorneys for Birch Solar 1, LLC

Attachment 1

Updated Figure 03-2

This figure supersedes and replaces Figure 03-1 that was submitted with the Application on February 21, 2021.

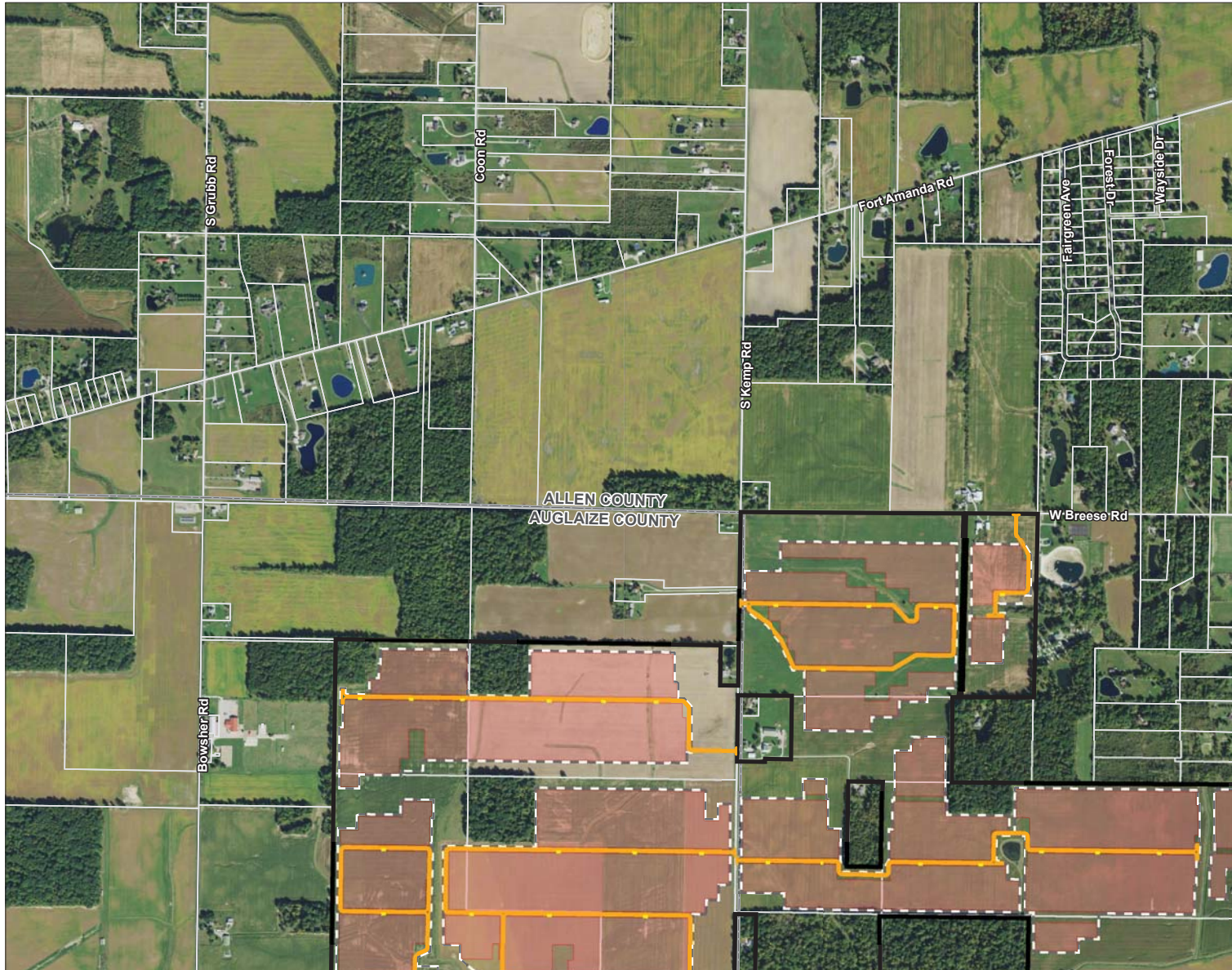


Figure No.

3-2

Title

Project Site Layout Map

Client/Project
Birch Solar 1, LLC
Birch Solar Project

2028113236

Project Location
Allen and Auglaize Counties, Ohio

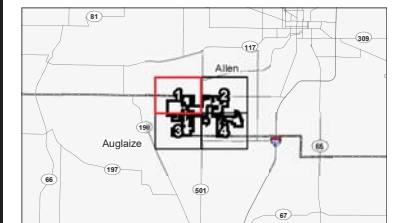
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TR by CA on 2021-01-23
IR by CMD on 2021-01-23



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Legend

- Project Area
- Parcel Boundary
- Solar Array
- Inverter
- Substation
- Gen-tie Line
- Fence
- Access Road



Notes

1. Coordinate System: NAD 1983 StatePlane Ohio North FIPS 3401 Feet
2. Data Sources: Stantec, Lightsource, USGS, NAD83/2011 Auglaize County AOS
3. Orthophotography: 2019 NAIP

Preliminary Design - Not for Construction



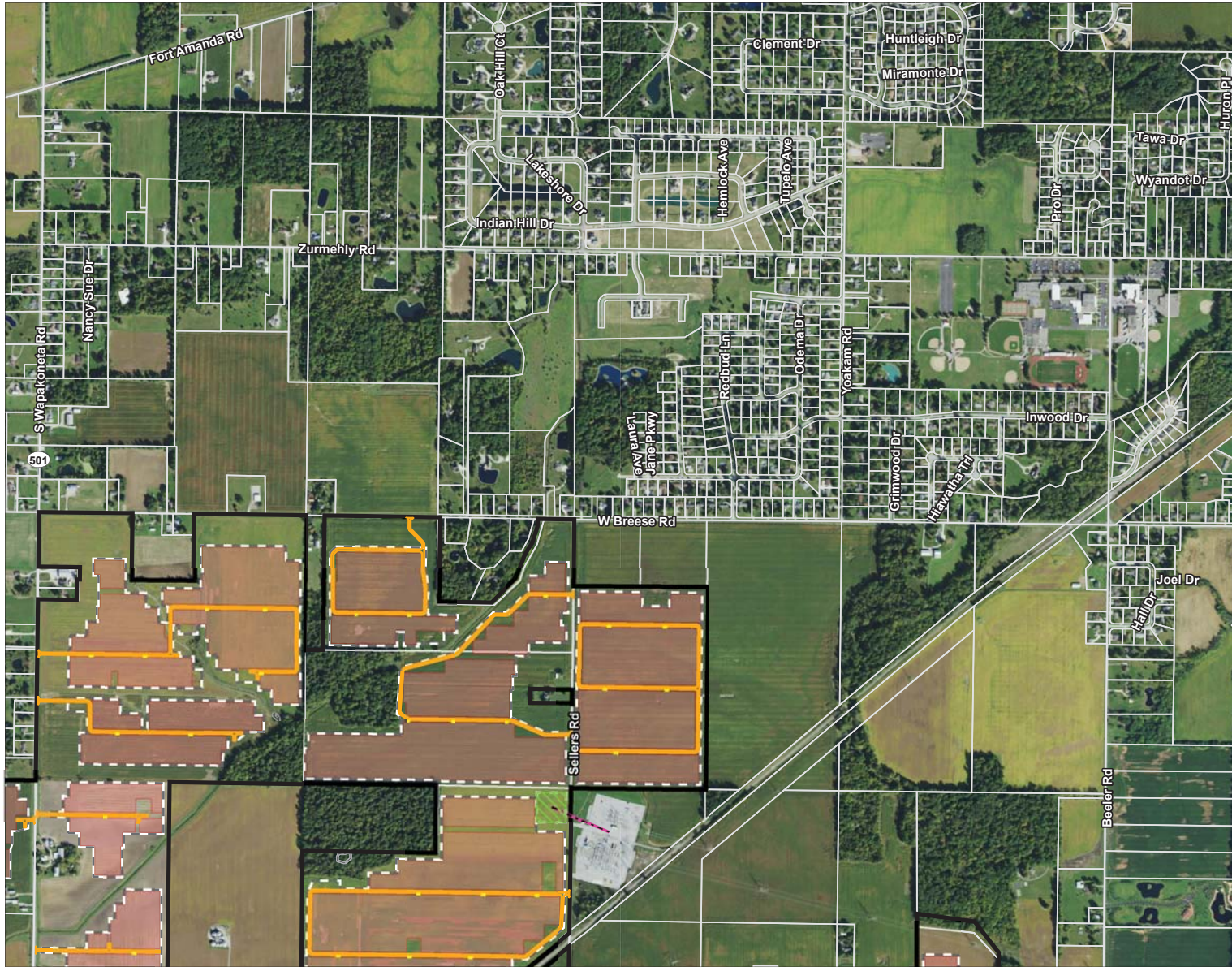


Figure No.
3-2

Title
Project Site Layout Map

Client/Project
Birch Solar 1, LLC
Birch Solar Project

2028113236

Project Location
Allen and Auglaize Counties, Ohio

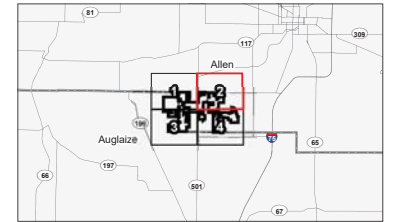
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Preliminary Design - Not for Construction



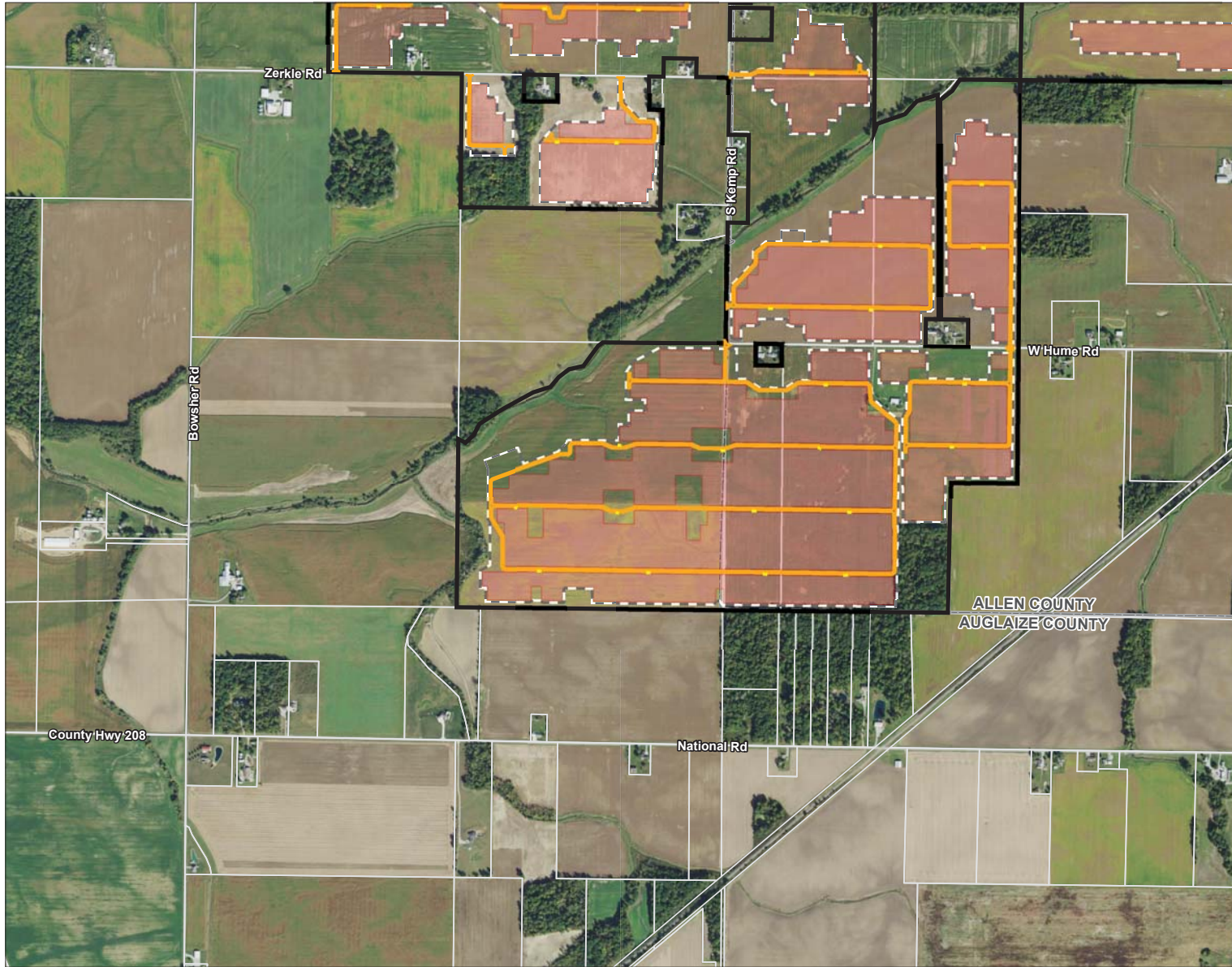


Figure No.
3-2

Project Site Layout Map

Client/Project
Birch Solar 1, LLC
Birch Solar Project

2028113236

Project Location
Allen and Auglaize Counties, Ohio

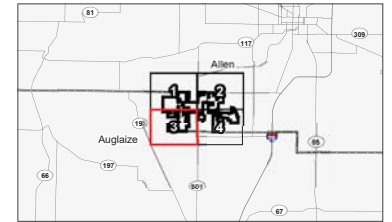
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Notes
1. Coordinate System: NAD 1983 StatePlane Ohio North FIPS 3401 Feet
2. Data Sources: Stantec, Lightsource, USGS, NAD83, GCS, GDA, GDA, GDA
3. Orthophotography: 2019 NAIP

Preliminary Design - Not for Construction



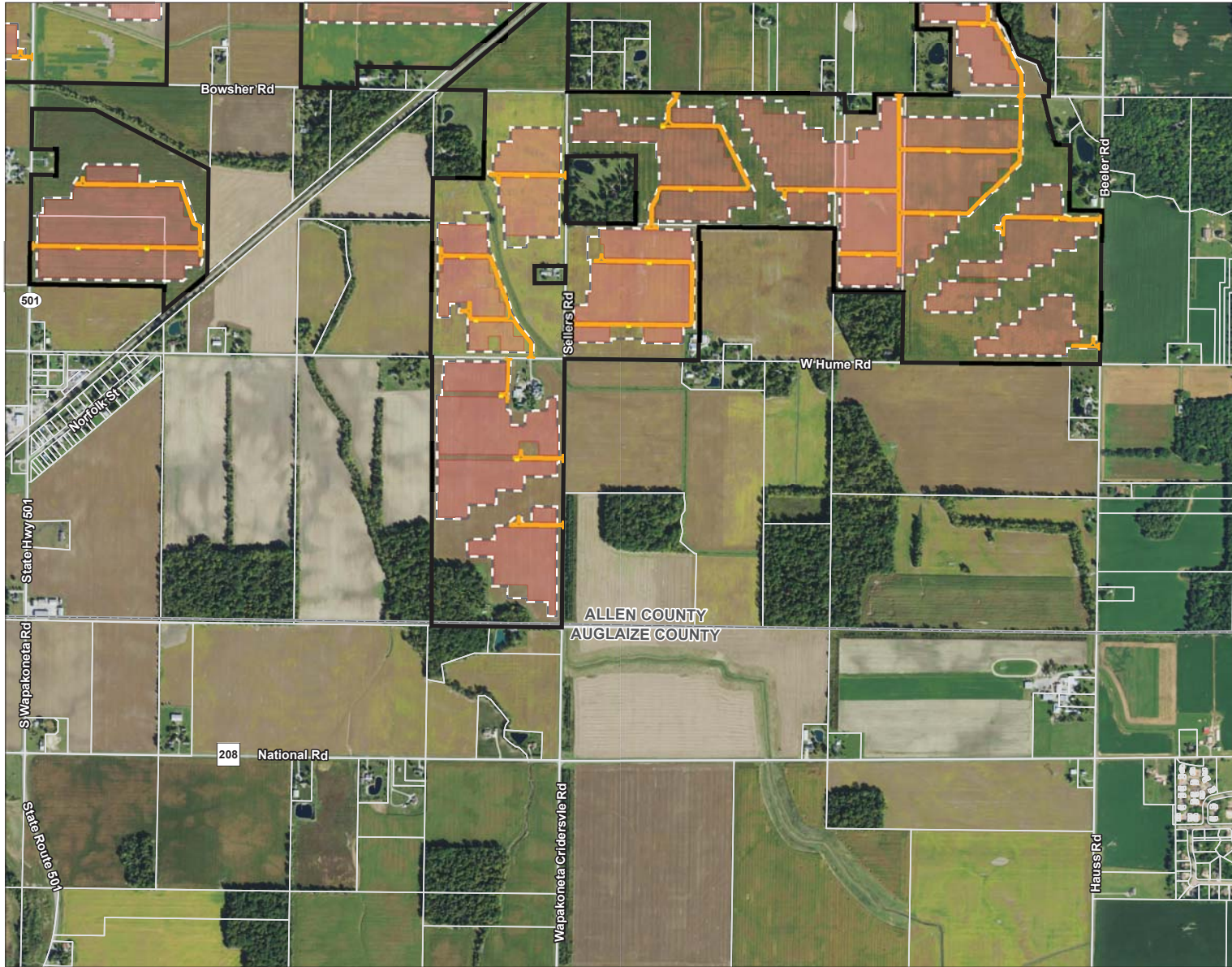


Figure No.
3-2

Title
Project Site Layout Map

Client/Project
Birch Solar 1, LLC
Birch Solar Project

2028113236

Project Location
Allen and Auglaize Counties, Ohio

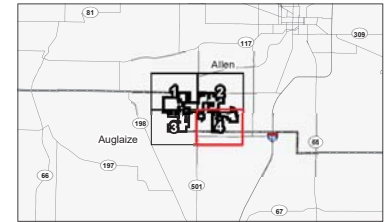
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1. Coordinate System: NAD 1983 StatePlane Ohio North FIPS 3401 Feet
2. Data Sources: Stantec, Lightsource, USGS, NAD83/CA Auglaize County AOS
3. Orthophotography: 2019 NAIP

Preliminary Design - Not for Construction



Attachment 2

Sample Emergency Action Plan

GRAB & GO

Bighorn Solar 1
1875 Lime Road
Pueblo, CO 81006

Emergency Response Plan Injury Reporting

Keep All Paperwork Together

All accidents or illness, regardless of classification, are to be reported to **McCarthy SAFETY IMMEDIATELY**. Subcontractor supervisors are to report to McCarthy. Reports are to be submitted to Safety manager within 24 hours of the occurrence. McCarthy Management and Supervisors are required to maintain up-to-date Certifications for CPR.

The Medical Clinics to be used location listed below:

Centura Centers Occupational Medicine
Phone: 719-562-6300
Hours: Monday- Friday 8:00am-5pm

Concentra
Phone: 719-545-0788
Hours: Monday- Friday 8:00am-5pm
Hours: Saturday 8:00am-4pm

All injured McCarthy employees are to be evaluated by McCarthy Safety and Occucare first before they are taken to Centura or Concentra and they must be accompanied by a McCarthy Building Companies, Inc. Safety/Management person, every injury/accident is required to do post injury/accident drug test.

If there are any questions, please call



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**In Case of a First Aid injury or beyond first aid care,
the following procedure will be implemented:**

ORDER OF SEQUENCE FOR FIRST AID INJURIES:

1. Injured employee to contact immediate Supervisor (GF/F/Superintendent).
 2. Superintendent to contact McCarthy Safety and Employee brought to Safety office (depending on the severity of injury). Also notify Mark Henderson, Steve Homan and Nick Partin.
 3. McCarthy Safety/EMT will determine injury classification, if first aid it will be handled in safety office, if beyond first aid care is needed Safety/Project Manager will contact Occucare to receive further instruction from Doctor.
1. If injured employee is:
 - a. A subcontractor employee – Subcontractor's competent person to assess the situation and follow company policies regarding first aid injuries. Subcontractor is to notify McCarthy Safety to assist in managing the first aid. **Report incident to**

**Emergency Response Plan for On-Site and Off-Site
In Case of an Emergency, the following procedure will
be**



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ORDER OF SEQUENCE IF ACCIDENT OCCURS THAT WILL REQUIRE EMERGENCY MEDICAL SERVICES:

1. Call _____ / _____ (Please call in order, only one contact needs to be made). Subcontractor to notify McCarthy immediately after contacting any Emergency medical services:
 - a. Emergency Dispatch- 911
 - b. Pueblo Sheriff Dispatch- 719-583-6250 or 911

2. McCarthy Management will go to their designated site entrances to receive medical emergency team and guide them to emergency site.
All Construction activities/ Radio communication are to cease immediately and keep Emergency Channel (#1) open also keep pathway cleared from entry point to emergency location.

3. Management Team will then immediately go to the Emergency location to fully assess the matter and offer aid if needed.

4. _____ and _____ will contact _____
or _____ will contact _____ immediately.
_____ is the ONLY McCarthy employee that can address the media.

5. Management Team will be making sure that all pathways to the Emergency remain clear.

6. If a McCarthy employee is injured, a McCarthy staff member will accompany the injured employee to the Hospital or Care Center. If it is a subcontractor, the sub's competent person shall accompany them to the Hospital or Care Center while keeping up communications with McCarthy staff.



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In the event that any of the above people are not available, _____ will communicate applicable revisions to the team. In case of _____'s absence, the team leader's duties will be passed on per the following sequence: (1) _____ (2)

_____ will be available 24 hours a day, 7 days a week. If circumstances change, _____ will notify the staff.

Note:

The person answering the phones shall get all details and contact the proper people at once. Order of sequence would be determined by how serious the accident is (For subcontractors, the designated Competent Person will make this determination).

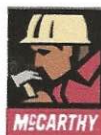
Emergency Evacuation Plan:

Each contractor's competent person must sign the Competent Person Log on a daily basis at the beginning of shift and fill in the proper head count of all their employees for the day. This log will be used to verify all personnel on-site have been accounted for in the event of an evacuation.

In the event of an emergency that would require evacuation, all on-site employees are to gather at the designated assembly areas that are discussed in the job site orientation (Note the attached Map).

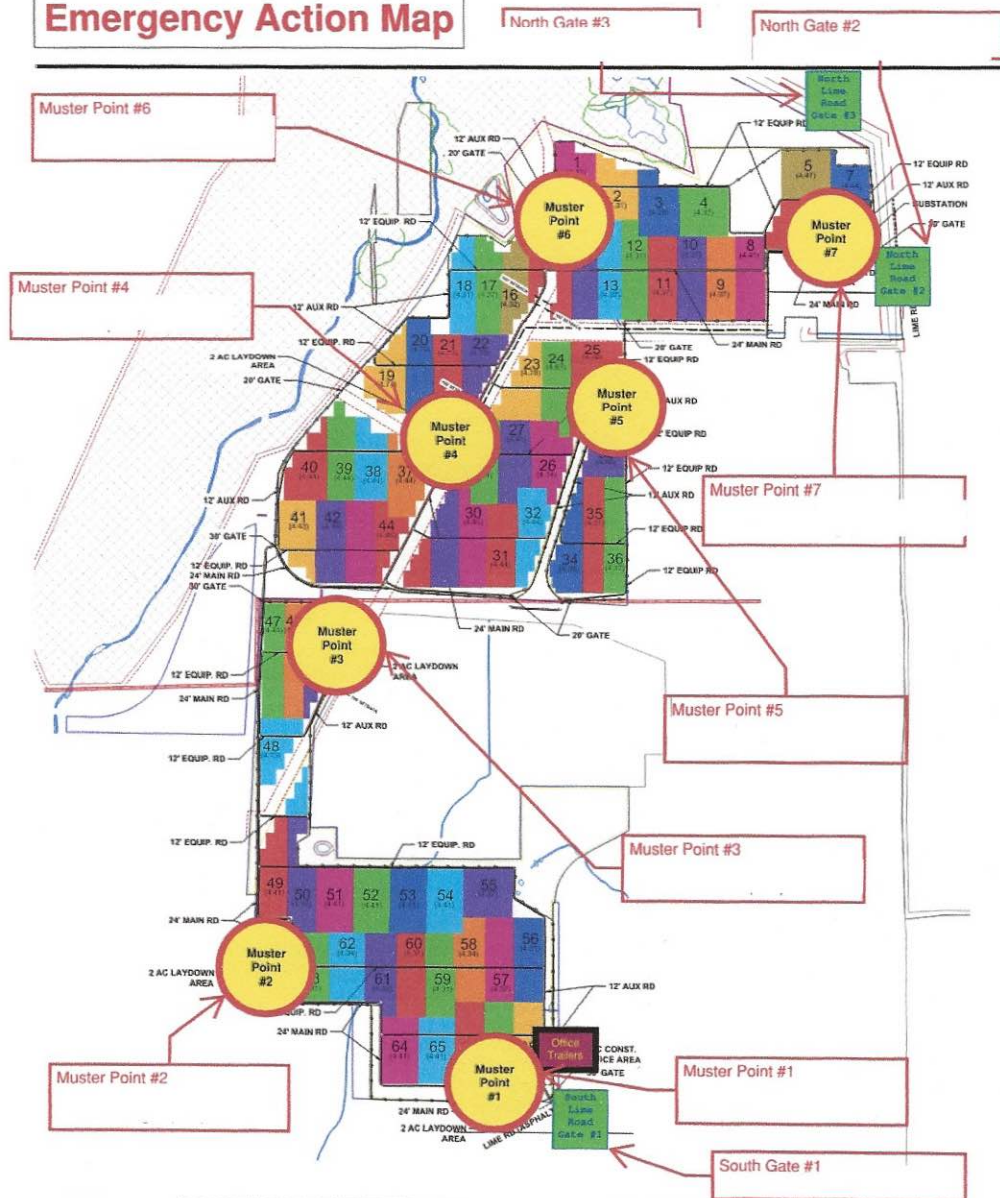
McCarthy management is to report to Muster Points 1-7. Roll call to be taken as soon as possible using Competent Person Logs documented in Procore. In the event of an active shooter or shelter in place, please use the following guidelines:

- Barricade in Place – Stay inside the construction zones and block the doors.
- Flee to Safety if you cannot Barricade in Place



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Bighorn Solar 1 Emergency Action Map



Muster Points

- Muster points to have signage visible from interior rows
- Muster points in parking lots or lay-down yards with enough space to allow for 6' social distancing
- Active Muster points will have supervision assigned to them for head counts
- Cooling/Heat & First Aid trailers located at each Muster Point

Gate Access Points

- Gate location supervisors will direct emergency responders and control unauthorized access
- Gates to have Stop/Slow paddles to assist in controlling traffic

Office Trailers

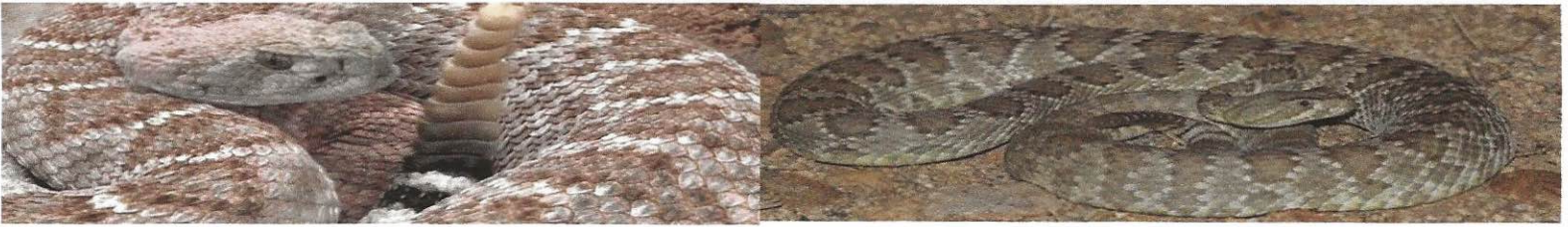
- Site notification to enact the emergency action plan will be regroup, whistles, radio and phone
- All work is to be made safe and everyone proceeds to the nearest Muster point
- No workers are to leave until head counts are verified and directed to leave by supervision
- Emergency radio communication will be channel 1, limit communication to allow for clear communication of pertinent information

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CONTACT PHONE NUMBERS

<u>Primary Contacts</u>	
(Sr. Project Manager)	
(Project Safety Manager)	
<u>Secondary Contacts</u>	
(Project Safety Manager)	
(Project Manager)	
(Superintendent)	
(Superintendent)	
(Superintendent)	





Outlook after a bite

The outlook for a person with a snake bite is highly variable. For a non-venomous snake bite, the outlook is excellent if the wound is cleaned and treated promptly. For a venomous bite, the outlook is good if the victim receives emergency care very soon after the bite has occurred. Healthy adults with shallow bites have a better outlook than children and those with weakened immune systems who have received deep bites.

About [7,000 venomous snake bite](#) cases are reported every year in the United States. A bite from a venomous snake is rarely deadly — only about 6 fatalities are reported every year. Snake identification and your reaction to the bite will make a big difference in the outcome.

Identifying a snake bite

A snake bite will typically have these things associated with it

- Two puncture wounds
- Swelling and redness around the wounds
- Pain at the bite site
- Difficulty breathing
- Vomiting and nausea
- Blurred vision
- Sweating and salivating
- Numbness in the face and limbs
- Severe pain
- Drooping eyelids
- Low blood pressure
- Thirst
- Tiredness or muscle weakness



Immediate actions taken after a bite

- We will try and determine if bite was from a venomous or non-venomous snake.
- If determined venomous or unable to find snake we will treat as venomous, 911 will be called to get a bird on the way. DO NOT move worker, provide shade over worker and keep them calm. The EMT will come out to the worker and clean the bite and monitor the worker. The worker will not be moved to the EMT's office.

Specific rattle snake bite symptoms

Symptoms specific to rattlesnake bites are immediate and include:

- Severe pain
- Drooping eyelids
- Low blood pressure
- Thirst
- Tiredness or muscle weakness

Snake bite first aid myths

These first aid techniques that are now believed to be unhelpful or even harmful:

- Do not use a tourniquet.
- Do not cut into the snake bite.
- Do not use a cold compress on the bite.
- Do not give the person any medications unless directed by a doctor.
- Do not raise the area of the bite above the victim's heart.
- Do not attempt to suck the venom out by mouth.
- Do not use a pump suction device. These devices were formerly recommended for pumping out snake venom, but it's now believed that they are more likely to do harm than good.



Snakes common to this area

- Prairie Rattlesnake (venomous)
- Bull Snake (non-venomous)
- Great Plains Rat Snake (non-venomous)
- Yellow belly racer (non-venomous)

Specific rattle snake bite symptoms

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- Do not use a pump suction device. These devices were formerly recommended for pumping out snake venom, but it's now believed that they are more likely to do harm than good.



Keep in mind

- One of the biggest things you can do to control your own outcome is to stay calm.
- When you are calm, your heart does not beat as fast and you will not circulate the venom as quickly.
- Also, keep in mind that although there are several different kinds of snakes on this site, the only one that is venomous is the rattle snake.
- Watch where you put your hands, snakes like heat and confined spaces. Think before you reach in somewhere or move something. Check out the porta john before sitting down or grabbing the toilet paper roll.
- DO NOT chase after the snake or try and grab it. Try and get a picture of the snake if you can, but DO NOT become a bite victim yourself trying to help.

Anti-Venom Providers

Parkview Medical Center

**400 W 16th St
Pueblo, CO 81003
719-584-4000**

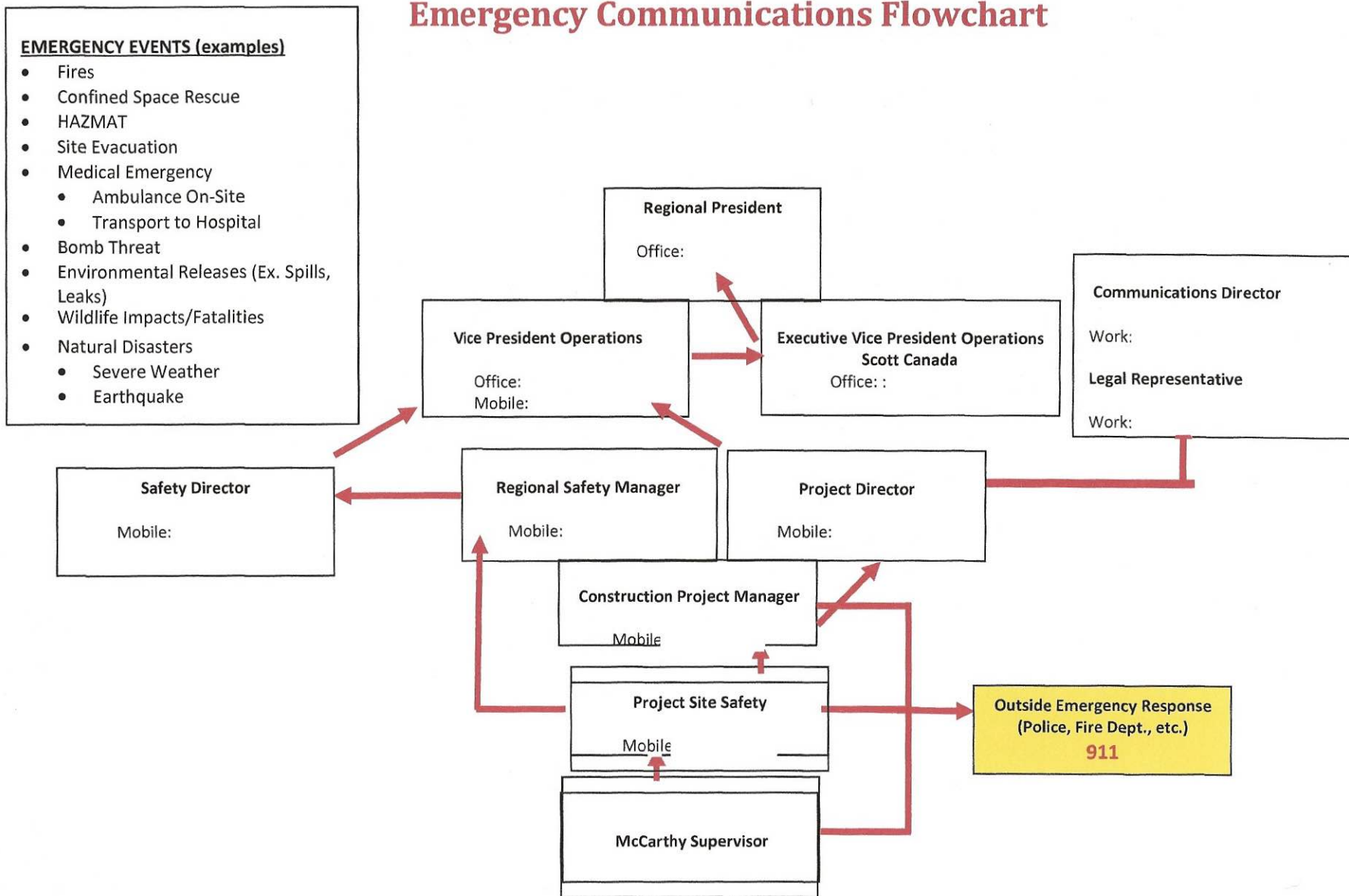
St. Mary-Corwin Medical Center 1008 Minnequa Ave

**Pueblo, CO 81004
800-228-4039**



Bighorn Solar 1

Emergency Communications Flowchart



SOUTHWEST REGION GRAB & GO

DATE		COMPANY/TRADE	
REPORT BY		EMPLOYEE	
JOB SITE NAME		JOB #	

ON SITE FIRST AID ONLY
MEDICAL FIRST AID ONLY
RECORDABLE INJURY
PERSONAL MEDICAL / NON-INDUSTRIAL
NEAR MISS INCIDENT
REPORT ONLY
AUTOMOTIVE / HEAVY EQUIPMENT DAMAGE
PROPERTY DAMAGE
SUBCONTRACTOR RECORDABLE INJURY

Review and follow McCarthy's 3.03 Emergency Management Plan

Category

QA. CRITICAL - CONTACT

1. Death or Life threatening injury
2. Structure or equipment collapse
3. Auto or equipment accident resulting in extensive damage or injuries

Notification: The lead McCarthy person on-site will call the Division President, Vice President of Operations, Business Unit Leader, Project Director, and Divisional Safety Director. (At least two (2) must be contacted).

B. SERIOUS - CONTACT

1. An accident in which individuals were hospitalized
2. Recordable or lost time injury for McCarthy employee
3. Any life-threatening injury to 3rd party non-construction worker
4. Major accident that results in property, vehicle or equipment damage
5. A near miss that could have resulted in serious injury to anyone or equipment

Notification: The lead McCarthy person on-site will call the Division President, Vice President of Operations, Business Unit Leader, Project Director, and Divisional Safety Director. (At least one (1) must be contacted).

C. SIGNIFICANT - CONTACT

1. Recordable injury for subcontractor or second/third tier subcontractor employee
2. Minor accident that results in property, vehicle, or equipment damage
3. Water infiltration or severe weather event

Notification: The lead McCarthy person on-site will call the Project Director and the Safety Director. For water infiltration events the Project Director and the Quality Director will be called, live contact is required.

GRAB & GO DOCUMENT CHECKLIST

*** BOLDDED ITEMS ARE MCCARTHY ONLY REQUIREMENTS**

** Italicized Items Are Subcontractor Only Requirements*

*** Regular Text Items To Be Used For Both**

- ☐ **Grab & Go Cover**
- ☐ **This Checklist**
- ☐ **Supplemental Report (Required for First Aid and Recordable Accidents)**
- ☐ Workmans Compensation Claim Submittal Form (Required for McCarthy Recordable Accidents Only)
- ☐ **Post Incident Drug Screen Authorization Form**
- ☐ **Employer's Report of Industrial Injury (ICA-04-0101)**
- ☐ **Doctor's Medical Treatment or Status Reports**
- ☐ *Subcontractor Accident Investigation Form*
- ☐ *Accident/Injury Report & First Report of Injury (Provided by Subcontractor)*
- ☐ **Injured Employee's Statement (This form can be shared with Subcontractors for their use)**
- ☐ **Supervisor's Statement (This form can be shared with Subcontractors for their use)**
- ☐ **Witness Statements (This form can be shared with Subcontractors for their use)**
- ☐ **Incident Information Summary (This form can be shared with Subcontractors for their use)**
- ☐ **McCarthy's THA or Subcontractor's Pre-Task Plan**
- ☐ **Any work plan or job scope documents (confined space, crane activity, hot work permit, etc)**
- ☐ **Photos / Pictures / Drawings of the incident**
- ☐ **Any Additional Relevant Information About the Incident (List Below)**
 - ☐ _____
 - ☐ _____
 - ☐ _____



2018

DESIGNATED PROVIDER LIST ACKNOWLEDGEMENT

TO: Injured Worker

FROM: _____

Date: _____

Dear _____
Employee name

A notice of your on the job injury was provided to us on _____. (date) For this injury, there are list of providers you can select to receive your treatment from. The providers are:

See Grab & Go Packet.

When you seek treatment, the provider should be advised this is an on the job injury and any required documentation will be supplied or acquired from your supervisor:

The authorized employer representative that you should contact concerning this claim is:

I _____, acknowledge receipt of the Designated Providers which was hand delivered/mailed on (date) _____.

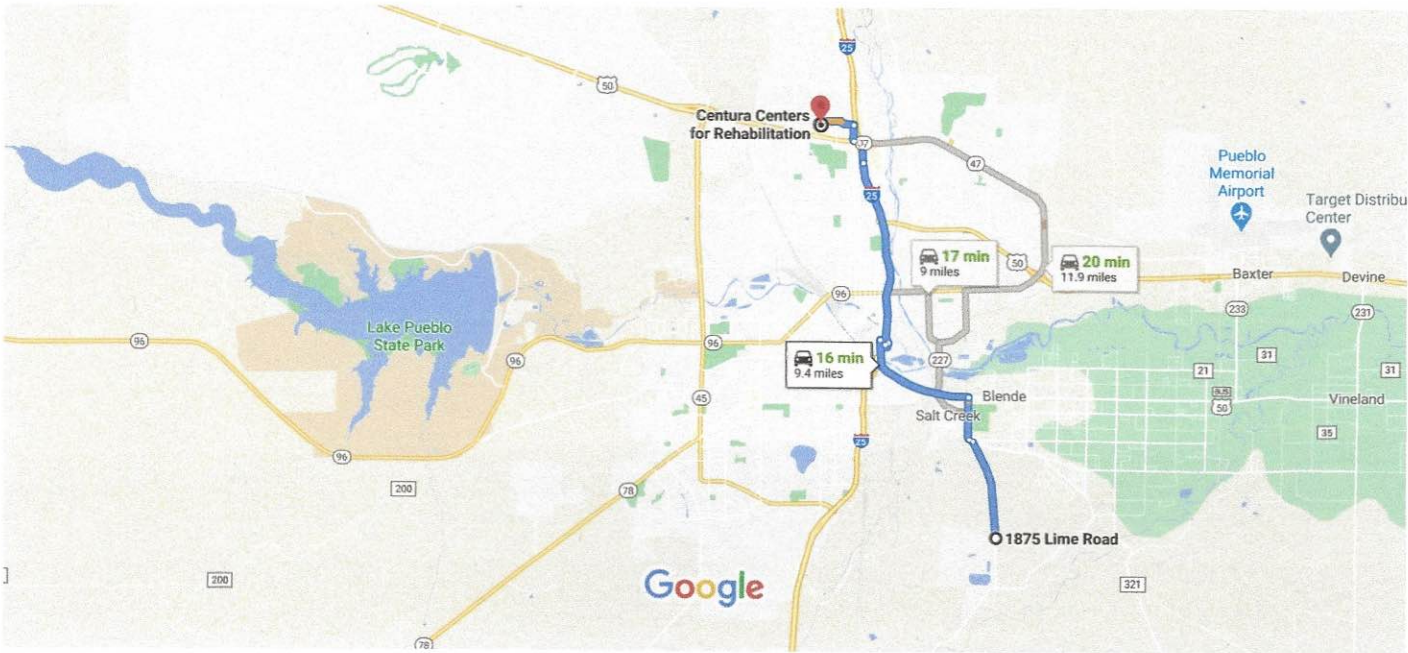
SAMPLE



1875 Lime Rd, Pueblo, CO 81006 to Centura
Centers for Rehabilitation

Drive 9.4 miles, 16 min

719-562-6300



Map data ©2020 2 mi

- via I-25 N **16 min**
Fastest route, the usual traffic 9.4 miles
- via CO-227 N/State Hwy 227 and I-25 N **17 min**
9.0 miles
- via CO-47 W **20 min**
11.9 miles

Explore Centura Centers for Rehabilitation

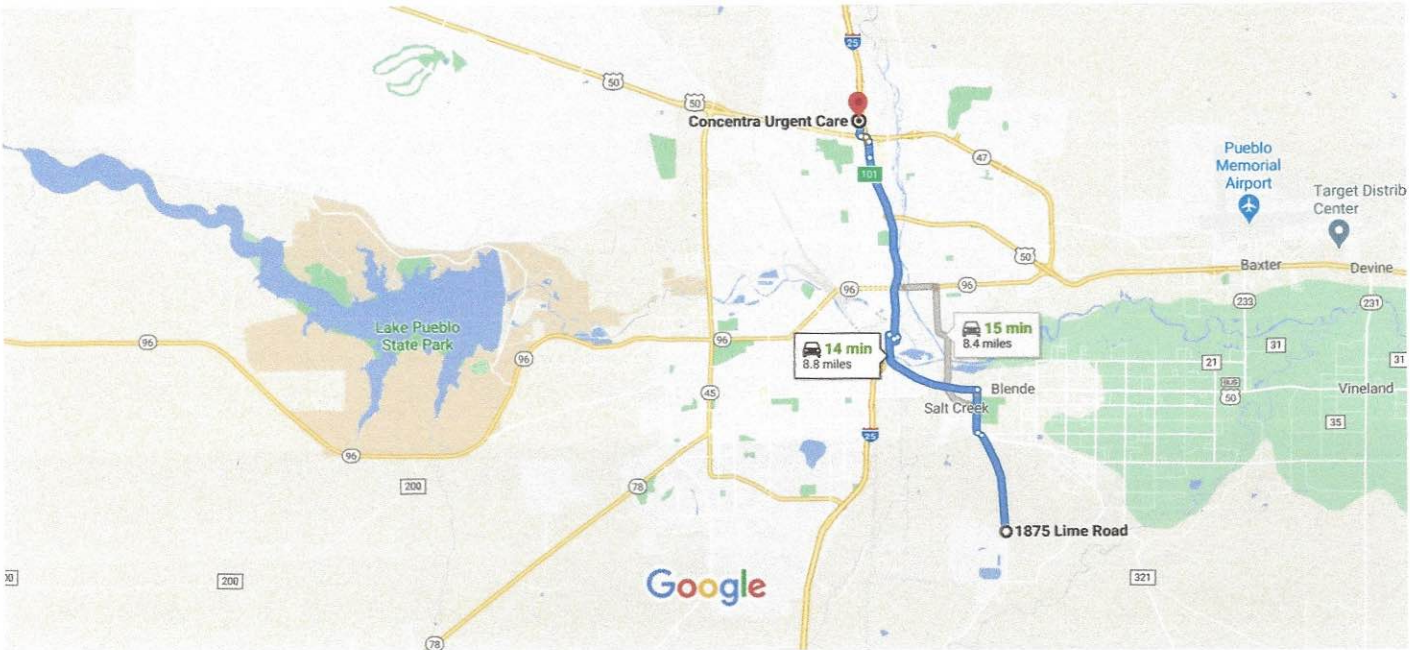
Groceries Hotels Gas stations Parking Lots More

SAMPLE



1875 Lime Rd, Pueblo, CO 81006 to Concentra Urgent Care
719-545-0788

Drive 8.8 miles, 14 min



Map data ©2020 2 mi

- via I-25 N

Fastest route, the usual traffic

14 min

8.8 miles
- via CO-227 N/State Hwy 227 and I-25 N

15 min

8.4 miles

Explore Concentra Urgent Care

Groceries Hotels Gas stations Parking Lots More



SUPPLEMENTARY REPORT OF INCIDENT

SAFETY INCIDENT SUMMARY		
Project:		
Incident Date:	Day of Week:	Incident Time:
Title:	Weather Condition:	
Description:		

EMPLOYEE INFORMATION			
	McCarthy/Castle Employee	Trade Partner Employee	Third Party Employee
Responsible Contractor	N/A		N/A
Lower Tier Contractor	N/A		N/A
Employee Name(s)			
Foreman			N/A
General Foreman			N/A
Superintendent			N/A
Supervisor			N/A
Employee Level			N/A
Trade Specialty			N/A
Time with Current Employer			N/A

SAFETY INCIDENT DETAILS	
Safety Incident Type: <input type="checkbox"/> Environmental <input type="checkbox"/> Fatality <input type="checkbox"/> Fire <input type="checkbox"/> First Aid <input type="checkbox"/> For Information Only <input type="checkbox"/> Lost Time <input type="checkbox"/> Near Miss <input type="checkbox"/> Non-Occupational <input type="checkbox"/> Other <input type="checkbox"/> Permitting <input type="checkbox"/> Property/Equip. Damage <input type="checkbox"/> Recordable <input type="checkbox"/> Restr. Duty	
Injury Type: <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Amputation <input type="checkbox"/> Chemical Burn <input type="checkbox"/> Contusion <input type="checkbox"/> Foreign Body <input type="checkbox"/> Fracture <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heat Related Illness <input type="checkbox"/> Hypothermia <input type="checkbox"/> Illness <input type="checkbox"/> Insect Bite <input type="checkbox"/> Laceration/Puncture <input type="checkbox"/> N/A <input type="checkbox"/> Non-Occupational <input type="checkbox"/> Other <input type="checkbox"/> Sprain/Strain/Tear <input type="checkbox"/> Thermal Burn	
Offsite Medical Treatment Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Body Parts Affected (if applicable):	
Accident Type (if applicable):	
# of Lost Workdays:	# of Restricted Workdays:
Tools, Equipment, Material Involved (if applicable):	

INVESTIGATION INFORMATION	
Person Responsible for Investigation:	
Safety Root Cause:	
Safety Sub-Cause:	
Direct Cause:	
Indirect Cause:	
Corrective Actions:	
Post Incident Findings:	
Additional Information:	
THA Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Post-Accident Drug/Alcohol Test: <input type="checkbox"/> Yes <input type="checkbox"/> No
Witnesses:	
Incident Occurred While Doing Rework: <input type="checkbox"/> Yes <input type="checkbox"/> No	
CSI Section:	

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Injury Assessment Form

To be used for initial &/or follow up communication with the Occucare Medical Consultant.

Date of injury / accident: _____

Time of injury / accident: _____

Location of injury / accident: _____

Name of injured Person: _____

Age: _____

Injury Description / Primary Complaint: _____

When did it happen? Exactly what time _____

What happened? _____

How did it happen? _____

Pain (Scale of 1-10): _____ (10 being the worst)

Where is the pain? _____

Describe the pain. (Throbbing, burning stabbing etc. _____

Radiation: does the pain travel to a different part of the body? _____

What are you seeing?

- ☐ Deformity
- ☐ Skin Injury
- ☐ Skin changes
- ☐ Joints
- ☐ Other

Description: _____

Pertinent medical history: (ie. previous related injuries to the current one):

Current medications (diabetes, blood thinners, heart disease): _____

Who communicated with the Medical Director? _____

Date(s) communication took place: _____



Professional
Medical
Risk
Management

24/7 Domestic Injury Management Consulting

If this is an emergency, please call 911. In order to consult with an Occucare International Medical Professional for assistance in assessing or caring for an injured coworker, call the following toll-free number:

CALL 866-268-0884

Prior to calling be prepared to provide the following information:

Please note, in order to increase efficiency during each call: It is of high importance that all safety professionals have photos of employee injuries ready to submit upon request at the time of the initial call.

1. CALLER

- a. Callback Number: _____
- b. Are you a safety professional? If not, who is? _____
- c. Name of Job Site: _____
- d. Date and Time of Injury: _____
- e. When was Company Notified: _____

2. INJURED EMPLOYEE

- a. First & Last Name: _____
- b. Date of Birth: _____
- c. Job Title: _____
- d. Are you a subcontractor or do you work for a temporary labor service? If so for whom? _____
- e. Injured Body Part (Right or Left): _____
- f. Any past injury or surgery to the injured body part? _____
- g. Are you taking any medications? _____
- h. Any known allergies or intolerances to medications? _____

3. DESCRIPTION OF INJURY

- a. In as much detail as possible what happened to cause the injury?

- b. What is the injured employee's current symptoms?

Once you have provided the Occucare nurse with the above information, the Occucare nurse will immediately patch you through to an Occucare medical provider.

Incident Information Summary

Incident Date	_____	Company / Trade	_____
Submitted by	_____	Employee Name	_____
Job Site Name	_____	Location	_____

Complete the information below upon interviewing the person/persons involved, witnesses, supervision, management or your own account of the incident.

1. Prepare a Timeline of the person involved in the incidents' workday.

2. What is your assessment of the Contributing Factors that led to the incident?

3. What were some of the Expanded Corrective Actions taken to prevent any reoccurrence?

4. What was the Root Cause of the incident or injury?

5. Do you have any other information you can provide?

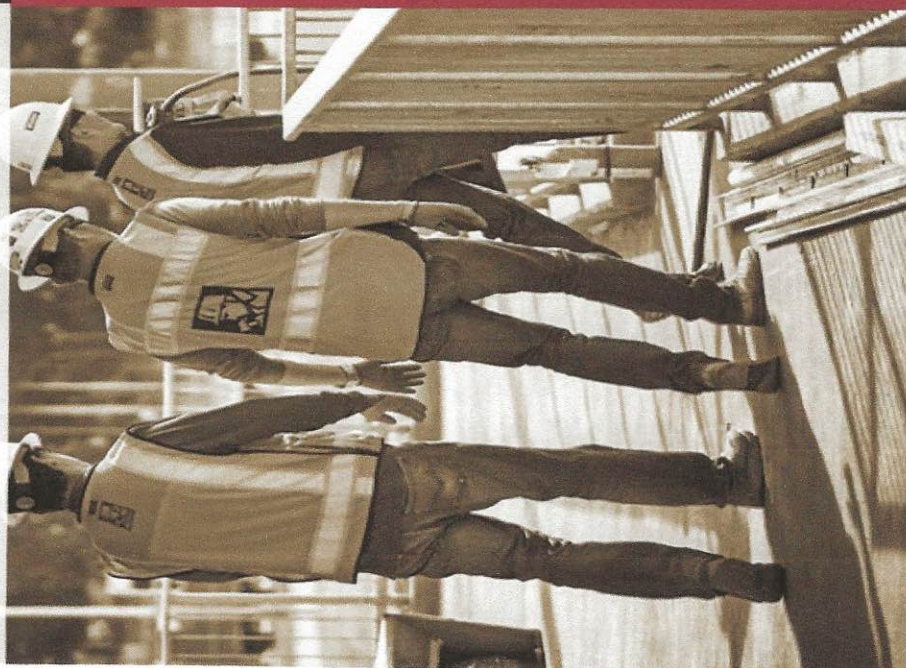
5 Why's Root Cause Analysis

Interactive Worksheet

MCCARTHY

SAFETY WORKS

A Genuine Safety Culture



5 Why's Root Cause Analysis Worksheet

why is it happening?

1.

Define the Problem:

why is that? ↓

2.

why is that? ↓

3.

why is that? ↓

4.

why is that? ↓

5.

We continue to have issues with employees

Caution: If your last answer is something you cannot control, go back up to the previous answer.

(continued analysis, enter answer from number 5 on previous page)

5.

why is that? ↓

6.

why is that? ↓

7.

why is that? ↓

8.

why is that? ↓

9.

Caution: If your last answer is something you cannot control, go back up to the previous answer.

Implement Corrective Actions

SAMPLE

Root Cause(s)	Counter Measures	Person(s) Responsible	Target Completion Date

**"Recordable"
Injuries
Only
Beyond this point**



SAMPLE

**AUTHORIZATION FOR SERVICES / VERIFICATION FORM
FOR PRE-EMPLOYMENT / POST-INCIDENT / CAUSE / RANDOM DRUG SCREENS**

Important: Photo ID and this form will be required at time of service.

***FIELDS MUST BE COMPLETE**

Company: <u>McCarthy Building Companies</u>	*Date: _____	*Time: _____
*Job #: _____ *Job Name: _____		

*Employee/Applicant Name: _____
*Employee/Applicant Social Security #: <u>XXX-XX-____</u> * (last four of Social Security Number)

<p>*CHECK 1 BOX IN SECTION 1 AND IN SECTION 2</p> <p>1. Type</p> <p><input type="checkbox"/> Pre-Employment</p> <p><input type="checkbox"/> Post-Incident</p> <p><input type="checkbox"/> Cause</p> <p><input type="checkbox"/> Random Drug Screens</p> <p>2. Panel Type</p> <p><input type="checkbox"/> Rapid ¹⁰-Panel Urine including BAT (Breath Alcohol Test) – Refer to protocol</p>

*McCarthy Employee Representative Print: _____	
*Date: _____	*Representative Email: _____
	*Representative Phone: _____

-----ATTENTION COLLECTION FACILITY-----

Employee/Applicant must leave facility with results in a sealed envelope per, McCarthy Protocol on file. Please make sure to bill each Employee/Applicant on a separate invoice with job number noted above, per McCarthy Protocol. Collector please initial _____

EMPLOYEE/APPLICANT: Immediately after taking test, please return this completed form with sealed envelope to your job site Admin or Safety Manager. Failure to do so could result in suspension, termination or refusal of employment.



WORKER'S COMPENSATION CLAIM SUBMITTAL FORM

INJURED EMPLOYEE Date Employer Notified of Injury _____

Name _____ Emp. No. _____

First Name _____ Middle Name _____ Last Name _____ State Code: _____

Residence Address: _____
No. & Street _____ City, State and Zip _____

Married ☐ Single ☐ Widowed ☐ Sex: Male ☐ Female ☐ Dependents _____

Date of Hire _____ Hourly Rate \$ _____ Birth Date _____

Occupation or Craft _____ Social Security Number: _____
Area Code and Telephone No. _____

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS

Job No. _____ Location and Address _____

Recordable: Yes ☐ No ☐ Immediate Supervisor _____

What was Employee doing when injured? How did the Accident happen? _____
(Be Specific)

If Employee was using tools or equipment or handling material, name them and tell what employee was doing with them. Describe fully the events

which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved. Give full

details. If needed, use reverse of this page.

Describe Injury in Detail Indicating Part of Body Affected _____

i.e., amputation of right index finger, fracture of ribs, dermatitis of the hands, etc.

Name the object or substance which directly injured the employee. For example, the machine or thing struck against or which struck employee, the vapor or poison inhaled or swallowed; or in case of strains, hemias, etc., the thing lifted or pulled, etc.

Date and Time of Injury: _____ Witness and Comments: _____

Did Employee see Doctor? Yes ☐ No ☐ Did Employee Return to Work? Yes ☐ No ☐; Estimate of Lost Work Days: _____

If Lost Time, please advise the Regional Safety Director of the Date Employee Resumes Work.

Prescriptions: Yes ☐ No ☐; Restricted Work: Yes ☐ No ☐; Post Accident Drug Test: Yes ☐ No ☐; X-Ray: Pos ☐ Neg ☐

Name and Address of Physician _____

If Applicable, Name and Address of Hospital _____

Date of Report _____

Foreman/Supervisor's Signature _____ Employee Number _____

Cost Code at Time of Injury: _____
(FROM TIME TICKET) Be Accurate - IMPORTANT

Superintendent's Signature _____ Employee Number _____

THIS FORM MUST BE COMPLETED IN FULL AND SENT TO THE REGIONAL OFFICE WITHIN 24 HOURS OF INJURY. THIS REPORT MUST BE SIGNED BY THE FOREMAN/SUPERVISOR AND THE SUPERINTENDENT.

See instructions on reverse side before completing form.

**COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION**

SAMPLE

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)		Social Security #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ()		OSHA Log #
Employee's street address			City		State	Zip code	
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown		Date of hire / /	Occupation	Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown		For Division use only
Employer's name			Employer's Federal ID #		Employer's phone # ()		
Employer's mailing address			City		State	Zip code	POB
Average weekly wage at time of injury \$ (see instructions on reverse side)		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance			NOI Coder
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are wages continued per C.R.S. 8-42-124? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No			
Injury/Illness date / / (See instructions on reverse side)	Time employee began work _____ <input type="checkbox"/> a.m. _____ <input type="checkbox"/> p.m.	Injury time _____ <input type="checkbox"/> a.m. _____ <input type="checkbox"/> p.m. <input type="checkbox"/> unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /	
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death				Injury occurred because of <input type="checkbox"/> Intoxication <input type="checkbox"/> Safety violation <input type="checkbox"/> Not applicable	
Tell us the part of body that was affected				Tell us the nature of the injury/illness ²			
What was the employee doing just before the accident occurred? ³							
Tell us how the injury occurred ⁴				What object or substance directly harmed the employee? ⁵			
Did injury occur on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code		Initial treatment (check one) <input type="checkbox"/> None <input type="checkbox"/> Emergency room <input type="checkbox"/> Minor on-site <input type="checkbox"/> Hospital >24 hrs <input type="checkbox"/> Clinic/hospital		Was the employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of witnesses				Name of employer representative notified			
Name and address of treating doctor or other health care professional				Name and address of facility where treated			
Completed by (name)		Title		Phone # ()		Date completed / /	
The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.							
Name of insurance company				Address			
Name of third party administrator (if applicable)				Address			
Adjuster name				Adjuster phone #			
Policy #	Carrier claim #		Date insurer received first report / /		Block #	Adj. Code	



**CLAIMS REPORTING QUICK REFERENCE SHEET
WORKERS' COMPENSATION CLAIMS**

Claim Line 1-877-265-5186

CLIENT INFORMATION:

- Insured Name and/or DBA (if a CCIP)
- Client #: 002125 (Master) or Client ID # for specific CCIP
- Subcontractor/Employer Name (CCIP Projects only)
- Reporting Unit/Project Number

INJURED WORKER INFORMATION:

- Employee Name
- DOB
- Social Security Number
- Address and home phone number
- Spouse's Name
- Date of Hire
- Title
- Gross pay per week
- Supervisor contact information

**CLAIMS REPORTING QUICK REFERENCE SHEET
WORKERS' COMPENSATION CLAIMS Page 2**

ACCIDENT INFORMATION:

- Exact date/time of injury/date reported by injured worker
- Exact location or site code where injury occurred
- Specific description of injury (i.e.: employee slipped and fell on wet floor in warehouse)
- Safeguards or safety equipment provided to prevent injuries (where applicable)
- Injured body parts
- Name and address of initial treating physician
- Name and address of clinic or hospital
- Witness contact information

For workers compensation claims, please mail all medical bills and accompanying medical reports to:

Gallagher Bassett Services, Inc.

P.O. Box 2831

Clinton, IA 52733-2831

All other correspondence is to be sent direct to the adjuster.

All medical bills and accompanying medical reports for the state of Nevada must be sent to:

Gallagher Bassett Services, Inc.

P.O. Box 400970

Las Vegas, NV 89140

If you need the **STATUS** on payment of a medical bill, please call:

800-370-0594

Attachment 3

Figure 1

Residential Visibility Assessment Map

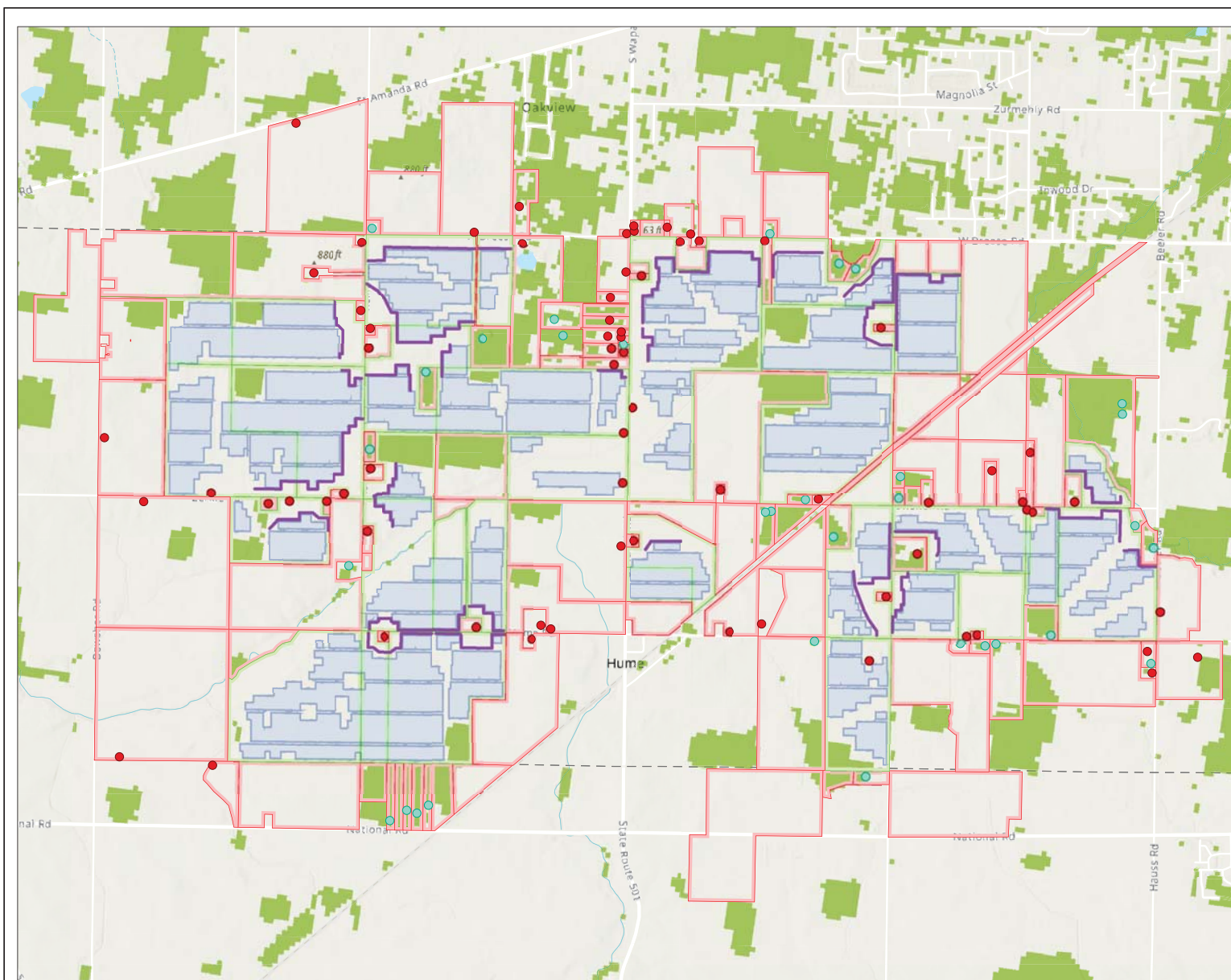


Figure No.
1

Residential Visibility Assessment Map

Client/Project
Birch Solar 1, LLC
Birch Solar Project

2028113236

Project Location
Allen and Auglaize Counties, Ohio

Prepared by J.L.H. on 2021-04-05
TR by AS on 2021-04-05
IR by CMD on 2021-04-05



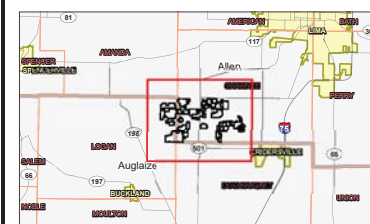
0 1,000 2,000
Feet
(At original document size of 11x17)
1:24,000

Legend

- Solar Array
- Participating Parcel
- Adjacent Parcel
- Vegetation
- Proposed Vegetative Screening

Residence*

- Not Visible
- Visible



Notes
1. Coordinate System: NAD 1983 StatePlane Ohio North FIPS 3401 Feet
2. Data Sources: Stantec, Lightsource Renewable Energy, Landfire, USGS, NADS
3. Orthophotography: Esri
4. Residential visibility indicates the theoretical visibility of solar panels 10 feet in height above the existing terrain to a 12 foot observer height (1-story building). 3 meter elevation data and existing vegetation height data were used for this analysis.



This foregoing document was electronically filed with the Public Utilities

Commission of Ohio Docketing Information System on

4/6/2021 8:12:39 PM

in

Case No(s). 20-1605-EL-BGN

Summary: Response to Second Data Request from Staff of the Ohio Power Siting Board
electronically filed by Christine M.T. Pirik on behalf of Birch Solar 1, LLC