Accident Reporting / Investigation Procedures

Accident Reporting & Notification

All job related injuries or illnesses, no matter how minor should be reported. The purposes for reporting accidents are threefold:

1. To ensure the health of employees by administering appropriate treatment as soon as possible after the injury;
2. To maintain a good, ongoing accident prevention program through investigation and elimination of accident causes;
3. For OSHA required documentation and recordkeeping.

For Accidents that Require Medical Attention

Notification by an appropriate supervisor is to be made to Human Resources within 24 hours of any report by an employee of an occupational injury or illness using the Employee Accident/Injury Form, the Accident Incident Witness Statement and a copy of the Medical Authorization form. All accidents involving serious bodily injury or death must be reported immediately.

A post-accident drug and alcohol screen is required for any employee seeking medical attention or if the accident or incident that resulted in property damage.

Employee must be driven/ escorted to receive post-accident care. Ambulances should only be utilized in absolute emergency situations.

- In most cases, the Nurse Practitioner Employee health should serve as the first contact for Worker's Compensation treatment and will refer the employee to a secondary provider or specialist if needed.
- Employees are NOT allowed to seek treatment from their own family physician or any other medical practice for work related injuries unless our Worker's Compensation Insurance Carrier has approved it in advance of treatment.
- **Employees may be required to personally pay for any medical bills submitted by medical providers not approved in advance of treatment by the City's Worker's Compensation Insurance Carrier**
- Chiropractic treatments for work related injuries are NOT allowed unless specifically approved in advance by the City's Worker's Compensation Insurance Carrier.
- If an employee reports an accident but does not seek medical attention on the day of the accident, then calls his or her supervisor on the next scheduled work day to state they are unable to report to work because of the accident, Human Resources must be notified immediately and the employee must be informed that they must be seen by one of the City's approved medical providers.
- After an accident report has been submitted, any change in an employee's status (unable to work, restricted duty, return to work, lifting of restricted duty) must be reported to Human Resources on the day the supervisor is presented with such information. Please make sure that the Human Resources receives copies of any excuses or return to work documents provided by the physician.
- **Please code time under the reason code as WC, as well as the paid time code as sick/vacation/holiday for all time missed due to Worker's Compensation.**

Accident Investigation

All occupational injuries/illnesses must be investigated as soon as possible after the occurrence in order to encourage successful accident prevention.

A critical part of the Accident/Injury Investigation Report is to ensure that the appropriate corrective action is taken to prevent recurrence.

The immediate supervisor shall be responsible for coordinating with the Division Safety Coordinator (DSC) to determine follow-up activity to eliminate the accident cause.

Procedures for Completing the Employee Accident/Injury Report

1. The employee's supervisor and DSC interviews the employee to determine the facts of the incident.

2. The supervisor and DSC complete the Accident/Injury Investigation Report.

3. The supervisor and DSC discuss the report with the employee.

4. The DSC sends a completed copy of the report to Human Resources within 3 business days (or as soon as possible if the employee or supervisor is not available). If the form cannot be completed within 3 days, the DSC should contact Human Resources to let them know when they expect to have the form completed.

5. The DSC discusses the incident with the employee's Division Head.

6. The DSC reviews the incident at the next Safety Committee meeting.

For Report Only Incidents/Property Damage Only

Notification by an appropriate supervisor is to be made to Human Resources within 24 hours of any incident report by an employee using the same Employee Accident/Injury Report.

- This form can be used for the following events: o Self-Administered First Aid (No Drug/Alcohol Screen Required) o Incident with Property Damage (Drug Alcohol Screen Required) o Motor Vehicle Accident with no injuries (Drug Alcohol Screen Required)

**Must submit FR-10 form (the driver or owner of each vehicle involved in an accident where there is property damage, injury or death must provide verification that the vehicle was properly insured. The investigating officer will provide both drivers with a green form (FR-10) **

- This form cannot be used to document exposure incidents

Approved Providers

The following medical organizations are approved to provide medical services to all City employees who have been injured as a result of an accident that occurred while on the job.

Primary Provider

City of Anderson Employee Health Clinic
601 South Main Street
Anderson, SC, 29624
Phone: 864-261-1000

Employee Health Clinic hours are as follows: Monday thru Friday: 8:30 a.m. - 4:00 p.m.
The Clinic will be closed for lunch each day between 12:30 p.m.-1:00 p.m.

After Hours Treatment

AnMed Health CareConnect
600 N Fant St
Anderson, SC 29621

- During the hours of 4pm – 8pm Mon-Friday or 8AM-5PM on Saturday-Sunday
- Located at behind helipad near Emergency Department entrance
- Completed City of Anderson authorization forms will be at CareConnect for the person accompanying the employee to sign for authorization.

If Clinic and CareConnect are closed, an employee should go to the Emergency Department.

AnMed Emergency Department
800 N Fant St
Anderson, SC 29621

(Inform the ER that you are an employee for the City of Anderson and your visit is due to a Worker's Comp Injury. The ER staff will know what to do from there.)

After Hours Post Accident Drug Screen and Breath Alcohol Test Only

Mon- Friday 4pm-7pm employees can go straight to Admitting at the AnMed Main Campus.
AnMed Main Campus (Front Entrance)
800 Fant St
Anderson, SC 29621

- Completed City of Anderson authorization forms will be at the lab for the person accompanying the employee to sign for authorization.
- After 7pm, employees should report to the Emergency Department for post-accident screening
- Employees who require a post-accident drug screen/post-accident Breath Alcohol test only must be referred to the Employee Health Clinic if the accident occurs between clinic hours.

DATE RECEIVED _____

(This form needs to be given to HR immediately following accident)

THE CITY OF ANDERSON

EMPLOYEE ACCIDENT/INJURY REPORT

OSHA RECORDKEEPING AND WORKERS' COMPENSATION

This report is to be submitted to Human *Resources in the event of an accident causing bodily injury/illness to an employee occurs during working hours within 24 hours. The report must be signed by both the supervisor and* the injured employee.

1. EMPLOYEE INFORMATION (MUST BE COMPLETE BY SUPERVISOR/MANAGER)

Name_____
First MI Last

Department: _____ Job Title: _____

Phone No. _____

Home Address_____ City_____ State_____ Zip Code_____

2. ACCIDENT/INJURY INFORMATION (MUST BE COMPLETED BY SUPERVISOR/MANAGER)

Place of Incident: _____ Date of Incident: _____Time of Incident: _____ Time Workday began: _____

Name of Supervisor: _____Date Supervisor Was Notified: _____

Did the employee complete their scheduled work day? Date of next scheduled work day? Will employee miss next scheduled work day?

Name of Injury/illness and part(s) of body affected (Please describe in detail, e.g. muscle strain, left, lower back)

_____

Describe what the employee was doing immediately before the injury. Be specific. (Example: "climbing a ladder while carrying roofing materials")

_____

_____

Describe in detail how the injury occurred. Be specific. (Example: "when ladder slipped on wet floor, employee fell 20 feet")

_____

_____

Were you trained on this task? ___Yes ___No Safety Equipment provided? ___Yes ___No ____N/A Was it used? ___Yes ___No
Did anyone witness the accident? ___Yes ___No Witness Name: _____ Witness Phone No._____

3. MEDICAL INFORMATION

____CLINIC – ANDERSON Address: 601 South Main Street City: Anderson State: SC Zip Code: 29624 _____HOSPITAL
ANMED Address: 800 North Fant Street City: Anderson State: SC Zip Code: 29621

Was Employee treated in an Emergency Room?_____Yes Was employee hospitalized overnight as an in-patient?_____Yes

_____OTHER: _____

4. SIGNATURE

The above details of this accident/incident are correct.

SIGNATURE OF EMPLOYEE: _____ DATE: _____

SIGNATURE OF SUPERVISOR: _____ DATE: _____

DATE RECEIVED _____
(HUMAN RESOURCES)

THE CITY OF ANDERSON

ACCIDENT/INJURY INVESTIGATION

To be completed by the employee's supervisor AND division safety coordinator.
Form must be submitted to Human Resources no later than 3 business days following the accident. If the form cannot be completed within 3 days, the DSC should contact Human Resources to let them know when they expect to have the form completed.

Employee Name	Job title/Department		Division Safety Coordinator
Location where Accident occurred	Date of Accident	Time of Accident	Date Return to Work
Summary of how the incident occurred?			
Part of boy affected/injured? (ex. Right foot, left elbow)			
Nature and extent of injury/illness and property damaged (be specific)			

PLEASE INDICATE USING "YES" OR "NO' TO ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS.

Yes ___ No ____Inadequate training
Yes ___ No ____Lack of knowledge/understanding/skill
Yes ___ No ____Failure to follow instructions/procedures
Yes ___ No ____Physical or mental impairment
Yes ___ No ____Unsafe position, improper lifting or loading
Yes ___ No ____Improper equipment use
Yes ___ No ____Unauthorized task/unauthorized area
Yes ___ No ____Improper guarding
Yes ___ No ____Failure to lock out
Yes ___ No ____Failure to secure

Yes ___ No ____Failure to wear PPE
Yes ___ No ____Inadequate/improper PPE
Yes ___ No ____Improper maintenance, servicing or inspecting
Yes ___ No ____Unsafe or defective equipment
Yes ___ No ____Inoperative safety device/failure to warn
Yes ___ No ____Unsafe operation or speed of car or other equip.
Yes ___ No ____Poor housekeeping
Yes ___ No ____Weather conditions
Yes ___ No ____Horseplay
Yes ___ No ____Other

Please explain any items marked Yes: _____

Explain in detail how this accident could have been prevented? _____

_____

Supervisor's detailed corrective action to ensure this type of accident does not recur: _____

Did employee promptly report the injury/illness? Yes ___ No ____ Is modified duty available? Yes ___ No ____

SIGNATURE OF SUPERVISOR: _____ DATE: _____

SIGNATURE OF SAFETY COORDINATOR: _____DATE: _____

Does this incident require further action or investigation from the Safety Committee? Yes ___ No ____

DATE RECEIVED _____
(HUMAN RESOURCES)

THE CITY OF ANDERSON

ACCIDENT/INJURY WITNESS STATEMENT

OSHA RECORDKEEPING AND WORKERS' COMPENSATION

(To be completed by Accident Witness)

Injured employee's name: _____

1. WITNESS INFORMATION

Name_____
First MI Last

Home Address:_____

City: _____ State: _____ Zip Code: _____ Phone No. _____

Department _____Position Title_____

2. ACCIDENT INFORMATION

Location of accident: _____

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected):

_____

_____

Recommendation on how to prevent this accident from recurring:

_____

_____

3. SIGNATURE

WITNESS SIGNATURE: _____ DATE: _____

Date Received: _____

(This form needs to be given to HR immediately following accident)

SC Municipal Insurance Trust

1411 Gervais Street
PO Box 12109
Columbia, SC 29211
Phone: 803.799.9574
Fax: 803.933.1295
Web: www.masc.sc

MEDICAL AUTHORIZATION

To Whom It May Concern:

The undersigned person hereby consents to, and by this authorization or any photocopy thereof, hereby authorizes the release to my employer or any agent or designee of my employer's insurance carrier and/or third party administrator, of any and all medical reports, histories, findings, prognosis, bills, information and other documents relating to any medical treatment hospitalization, prescription drugs, or other medical services or supplies, including psychiatric treatment or treatment for alcoholism or drug abuse of such patient.

The undersigned person understands that my employer and its agents, designees and insurance carrier/third party administrator, may, from time to time, find it necessary to obtain information verbally and/or in writing from my treating health care provider. Pursuant to R.67-1308 (B)(1), this medical authorization constitutes notice that the employer and its agents, designees, and insurance carrier/third party administrator will communicate verbally and in writing with my healthcare providers. By executing this medical authorization, the undersigned waives the ten day notice requirement set for in R.67-1308(B)(1) and authorizes the communication.

The undersigned person understands and hereby acknowledges that the information above or certain portions thereof may be protected from disclosure without this signed authorization of federal and state privacy and confidentiality laws.

A photocopy of this authorization will serve as an original.

Patient Name:

Social Security No.:

Birth:

Patient Signature: _____ Date: _____