Incident Reporting and Investigation Sample Documents

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Purpose

The District's Incident Reporting and Investigation Plan prescribes methods and practices for reporting and investigating injuries and/or accidents. The Plan provides a means to ensure compliance with workplace and vehicle/equipment accidents in a standardized way to ensure compliance with all workman's compensation laws and regulations. Another goal of Incident Reporting and Investigation is to learn from the incidents and adjust work practices to mitigate future incidents.

The Incident Reporting and Investigation Plan contains two sections. The first section describes the reporting and investigation procedures for work related injury accidents while the second section describes reporting and investigation procedures for vehicle and equipment accidents which do not result in injury to a District employee.

Work-Related Injuries

The District has designated Colorado Special Districts Property and Liability Pool (CSD Pool) and as its workman's compensation insurance provider. The District has also designated a medical provider to be used for all work-related injuries, *[Enter Medical Provider Here]*. All work-related Incidents resulting in injury, or potential injury will be reported and investigated in accordance with the following procedures.

Injury Reporting Procedures

- Employees injured on the job are to report the injury to their immediate supervisor and the Safety/District Manager immediately, if possible, but no later than forty-eight (48) hours after the injury.
- Any employee witnessing an injury at work is to immediately call for emergency help and provide any assistance required. If the witnessing employee cannot directly contact emergency help, they are to notify the District office to contact emergency help as needed at the site of the injury. The witnessing employee is to give detailed information regarding the accident/incident causing the injury and the location of the injury. In addition, the injured employee or witnessing employee is to report the accident/incident and injury to their immediate supervisor.
- The injured employee's immediate supervisor is to complete the District's Supervisor's Accident/Incident Report (Appendix B) with the injured employee and any witnesses as soon after the accident/incident as possible, but no later than forty-eight (48) hours after receiving notification of the injury. The injured employee's immediate supervisor is to notify the [Insert Safety Manager Name/Position Here] of the injury and provide a copy of the Supervisor's Accident/Incident Report within the same day he or she has been notified.
- The injured employee is to complete the Employee Written Notice of Injury Notice (Appendix A) to Employer Form within twenty-four (24) hours of the injury, if possible, but no later than forty-eight (48) hours after the injury. A copy should be provided to the [Insert Safety Manager Name/Position Here].
- The District Manager is to notify CSD Pool within twenty-four (24) hours of the injury, if possible, but no later than forty-eight (48) hours after the injury. If the investigation is not completed within twenty-four hours of the injury, the investigation report will be sent to CSD Pool as soon as it is completed to follow up with the first report of the injury. The [Insert Safety Manager Name/Position Here] is to complete the Employer's First Report of Injury for all reported injuries and attach doctor statements and forms if applicable.
- Injured employees in need of medical attention, must report to the District's designated medical provider (Enter Medical Provider) with a HIPPA Compliant Authorizations for Release of Medical Information (Appendix C) prepared by the [Insert Safety Manager Name/Position Here]. In case of an emergency in which the [Insert Safety Manager Name/Position Here] is not available, the employee is to go directly to the designated medical provider.
- The designated medical provider must have authorization from the District before any treatment for a work-related injury can be performed. Authorization is to be given by the [Insert

Safety Manager Name/Position Here], or in the absence or unavailability of the [Insert Safety Manager Name/Position Here], the District Manager or the employees immediate supervisor. If authorization cannot be obtained, the injured employee shall present his medical insurance card to receive treatment under the District's medical insurance plan. The [Insert Safety Manager Name/Position Here] must be notified as soon as practical, but no later than forty-eight (48) hours after treatment is performed in this manner.

- All doctor statements and forms must be submitted to the [Insert Safety Manager Name/Position Here] as soon as possible, but no later than twenty-four (24) hours after treatment is performed.
- Employees with a workplace injury resulting in lost time from work shall be enrolled into the District's Return to Work Program.

Incident Investigation Procedures

Thorough accident/incident investigations will help the District determine why accidents/incidents occur, where they happen, and any trends that may be developing. Such identification is critical to preventing and controlling hazards and potential accidents/incidents.

- The immediate supervisor is to conduct an incident investigation with the [Insert Safety Manager Name/Position Here], if possible, at the scene of the accident/incident as soon as possible after the incident. The injured employee will be asked to make a detailed report of the events that led up to and resulted in the incident. All witnesses to the incident will be interviewed separately.
- The immediate supervisor is to complete the Incident Investigation Report and submit it to the [Insert Safety Manager Name/Position Here] along with the Supervisor's Accident/Incident Report.
- The [Insert Safety Manager Name/Position Here] and the immediate supervisor are to review the Supervisor's Accident/Incident Report and the Incident Investigation Report to determine the cause or potential cause of the incident and remedial actions that may be taken to prevent a reoccurrence.

Return to Work Program

The purpose of the Return to Work Program is to help enable healthy recovery and resumption of full capabilities by injured employees whose injury initially restricts their ability to perform their normal job duties. Employees are the District's most important asset and the District strives to ensure the best possible safety, health, and performance for every employee.

The following steps are to be taken by the injured employee after they have been diagnosed by a physician for any injury:

- Report the injury to their immediate supervisor and the [Insert Safety Manager Name/Position Here] as soon as practical, but no longer than forty-eight (48) hours after the injury.
- Submit any doctor statements and work duty restrictions to their immediate supervisor and Safety Manager as soon as practical, but no longer than forty-eight (48) hours after treatment of the injury. No modified duty assignments or loss time will be granted without written medical restrictions from the diagnosing physician.
- The employee will be required to follow the diagnosing physician's restrictions. When written assessment from the physician indicates that the employee can return to normal duties, the Safety Manager will inform the immediate supervisor to return the injured employee to normal work duty.

The following steps are to be taken by the Safety Manager once he has been informed of the employee's restricted status:

- Request the diagnosing physician to verify the written medical restrictions on the employee and send a copy to the workman's compensation insurance company.
- Request the injured employee's supervisor to determine a modified duty assignment based on the written restrictions and have the modified duty assignment accepted by the diagnosing physician.
- Inform the injured employee of the modified duty assignment and the start date thereof. If the injury was work related, it is required that the injured employee return to work and begin the modified duty assignment on the date specified.
- Request the diagnosing physician to make weekly assessment reports on the restriction status of the injured employee. When written assessment from the physician indicates that the injured employee can return to normal duties, the Safety Manager will inform the immediate supervisor to return the injured employee to normal work duty.

Vehicle and Equipment Accident Reporting and Investigation

The following steps are to be taken in the case of a vehicle or equipment accident resulting in property damage.

Accident Reporting Procedures

- The employee involved in a vehicle or equipment accident should first check for injuries to anyone involved in the accident. In the case of injuries, the employee is to call for emergency help and provide assistance if required. If the employee cannot directly contact emergency help, they are to notify the District office to contact whatever assistance is needed at the accident. Any witnessing employee is to give detailed information of the accident and location of the accident. In addition, the employee involved in the accident is to report the accident to their immediate supervisor.
- If a vehicle accident involves another party, the employee is not to admit any liability involving the accident. The employee is to contact the appropriate policing authority as soon as possible. If the accident involves a CDL vehicle (over 26,000 lbs.) the employee is to immediately notify their immediate supervisor or the Safety Manager and submit themselves to a mandatory post-accident drug and alcohol test as specified in the in Compliance with the Federal Omnibus Transportation Employee Testing. Delete if this does not apply
- The employee is to exchange information (name, address, phone number, insurance carrier, policy number, and vehicle license plate number) with the other party involved in the accident and provide that information to the immediate supervisor.
- All accidents are to be reported to the immediate supervisor immediately or as soon as possible, but not later than forty-eight (48) hours after the accident.
- The employee's immediate supervisor is to complete the Supervisor's Incident Report with the employee and any witnesses as soon as possible but no later than forty-eight (48) hours after the accident.
- The immediate supervisor is to notify the [Insert Safety Manager Name/Position Here] and submit the written Supervisor's Incident Report as soon as possible but no later than forty-eight (48) hours
- Upon notification of an accident, the District Manager will notify the appropriate insurance company of the accident. The District Manager will give as much information as possible, including a copy of the Supervisor's Incident Report and the Incident Investigation Report and any other reports requested by the insurance company.

Accident Investigation Procedures

Thorough accident investigations will help the District determine why accidents occur, where they happen, and any trends that may be developing. Such identification is critical to preventing and controlling hazards and potential accidents.

- The immediate supervisor is to conduct an accident investigation with the [Insert Safety Manager Name/Position Here] if possible, at the scene of the accident as soon as possible after receiving notice. The employee will be asked to make a detailed report of the events that led up to and resulted in the accident. All witnesses to the accident will be interviewed separately.
- The immediate supervisor is to complete the Incident Investigation Report and submit it to the [Insert Safety Manager Name/Position Here] along with the Supervisor's Incident Report.
- The [Insert Safety Manager Name/Position Here] is to review the Supervisor's Incident Report and the Incident Investigation Report to determine the potential cause of the problem and possible remedial actions that may be taken to prevent reoccurrence.

Policy Evaluations and Updates

It is our goal to maintain a safety program that is understandable, effective and one that promotes a safe work environment. Any employee can make recommendations for improvement to this program or any other aspect of our safety system. These suggestions should be directed to any member of management, any safety committee member or to the safety administrator.

As a matter of policy, this program will be reviewed on an annual basis by the safety administrator to determine if all aspects still meet the needs of this organization. If there are significant events that take place during the year that indicate the program is less than effective, an immediate evaluation will be conducted and appropriate steps taken to increase the reliability of this plan.

Date of Review	Name of Reviewer	Changes Required (Yes or No)	Current Revision Number

Please use and attach additional revision log updates on a separate document as necessary.

Colorado Special Districts Property and Liability Pool

Employee's Written Notice of Injury to Employer

Please read instructions on reverse side before completing this form.

1.	Name of Employer:		Phone:
2.	Name of Injured Employee:		Social Security#:
3.	Home Address:		Phone:
4.	Age:	5. Birth Date:	6. Sex:
7.	Employee Date of Hire	8. Employee occupation:	
9.	Place of accident/exposure: (see instructions on reverse side) (No. & Street) (City) (State) (Zip)		
10.	What was employee doing when injured? Be specific. If using tools or equipment, name them and tell how they were being used.		
11.	How did the accident occur? Describe fully the events which resulted in the injury/occupational illness. Tell what happened and how it happened. Give full details on all factors which led or contributed to the accident/exposure. Use separate sheet if additional space is needed.		
12.	Name the object or substance which directly affected the employee: For example, the machine or thing he struck against or which struck him; the vapor or poisons inhaled or swallowed; the chemical or radiation which irritated the skin; or in the case of strains, hernia, etc, the thing lifted, pulled, etc.		
13.	Describe the injury/illness in detail and indicate the part of the body affected: For example, amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand; etc. (medical description).		
14.	Date of Injury:	Time:	Working shift: from to
15.	Was employee able to continue work after the injury? Yes ☐ No ☐		If no, date left work:
	(b) Has the Employee Returned to Work?	(c) If so, give date:	
	(d) If not, probable length of disability:	(e) Did injury/illness force employee to transfer to a different assignment?	
16.	Date of last job-related injury/illness:		
17.	Prepared by: (employee signature)		Date:

Employee and Employer: See Reverse Side for Important Notice

READ CAREFULLY 8-43-102. Notice to employer of injury - notice to employees of requirement - failure to report. [Editor's note: This version of section 8-43-102 is effective August 10, 2022.] (1) (a) (I) Every employee who sustains an injury resulting from an accident shall notify the employee's employer in writing of the injury within ten days after the occurrence of the injury. If the employee is physically or mentally unable to provide the notice, the employee's foreman, superintendent, manager, or any other person in charge who has notice of the injury shall submit written notice of the injury to the employer. Any other person who has notice of the injury may submit a written notice to the person in charge or to the employer, and in that event the injured employee is relieved of the obligation to give the notice. Otherwise, if the employee fails to report the injury in writing, the employee may lose up to one day's compensation for each day's failure to report. If the employer fails to provide a copy of the employee's written notice pursuant to subsection (l)(a)(I I) of this section, or if, at the time of the injury, the employer failed to display the notice specified in subsection (l)(b) of this section, the time period allotted to the employee is tolled for the duration of time that the employer fails to provide the written notice and display the notice. If the employer has actual notice of the injury or good cause is shown for the failure of the employee to report the injury in writing, there is no loss of compensation pursuant to this subsection (1) for the failure to report the injury.(11) An employer who receives written notice of an injury pursuant to this subsection (1) shall affix the date and time of the receipt on the notice and shall make a copy of the notice affixed with the date and time ofreceipt available to the injured employee within seven days after receiving the notice. An employer is not subject to a penalty under articles 40 to 47 of this title 8 for failing to provide the injured employee a copy of the notice required by this subsection (l)(a)(II).

INSTRUCTIONS TO EMPLOYEE

I. All injuries, no matter how trivial, must be report to your employer.

2. Forms should be typed or printed legibly.

3. Instructions for Question 9:
If an accident/exposure occurred on employer's premises, give address of plant or establishment in which it occurred. If it occurred outside employer's premises at an identifiable address, give that address. Ifit occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of accident or exposure as accurately as possible.

INSTRUCTIONS TO EMPLOYER

I. Pool's claims administrator will complete the Employer's First Report of Injury and send you a copy. They will also send the injured workers a copy of the Employer's First Report of Injury form with their first contact letter.

2. All incidents must be reported to the Pool's claims administrator to be compliant with 8-43-102.

EMPLOYER'S ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE'S NOTICE OF INJURY

Completed form received from employee on ______________ at ______________am/pm
(date)

by: ____
employer representative

completed copy of this form provided to employee on ____________________
(date)

Supervisor's Accident/Incident Report

Complete this form in its entirety and send to your Sedgwick adjuster.

Note to Employer: It has been established that accidents cost the employer directly approximately four times the amount of compensation, liability and medical expenses.

District (Supervisor ONLY to make out Report) ______________________

City and State ______________________ Location of Accident ______________________

Date of Accident ______________________ Hour of Accident ______________ ☐AM ☐PM

Name of Injured Employee ______________________

Date of Hire ______________________

What were Injured Employee's Duties? ______________________

Fully Describe the Nature of the Accident (below)

Check causes of accident below: Accident causes

I. Unsafe Practices

A. Instructions

☐(A) None ☐(B) Not Enforced

☐(C) Incomplete ☐(D) Erroneous

B. Ability of Employee

☐(A) Inexperienced ☐(B) Unskilled

☐(C) Ignorance ☐(D) Poor Judgement

C. Discipline

☐(A) Disobedience of Rules

☐(B) Interference by Others

☐(C) Fooling

II. Unsafe Condition

A. Physical Hazards Incl. Mechanical, Electrical Steam Chemical Conditions, etc.

☐(A) Ineffectively Guarded

☐(B) Unguarded

B. Housekeeping

☐(A) Improperly Piled or Stored Material

☐(B) Congestion

C. ipment

☐(A) Defective Tools

☐(B) Defective Machines

☐(C) Defect of Misc. Materials & Equipment

C. Concentration to Job

- [ ] (A) Attention Distracted
- [ ] (B) Inattention

D. Unsafe Conditions

- [ ] (A) Fire Protection
- [ ] (B) Exits
- [ ] (C) Floors
- [ ] (D) Openings
- [ ] (E) Miscellaneous
- [ ] (F) Weather

E. Unsafe Practices

- [ ] (A) Chance Taking
- [ ] (B) Short Cuts
- [ ] (C) Haste

D. Working Conditions

- [ ] (A) Poor Ventilation
- [ ] (B) Inadequate Sanitation
- [ ] (C) Inadequate Light
- [ ] (D) Excessive Noise

F. Temperament

- [ ] (A) Sluggish or Fatigued
- [ ] (B) Violent Temper
- [ ] (C) Excitability

E. Workplace Hazards

- [ ] (A) Layout of Operations
- [ ] (B) Layout of Machinery
- [ ] (C) UnSafe Processes

F. physical Condition

- [ ] (A) Fatigued
- [ ] (B) Weak
- [ ] (C) Taking Medication

G. Dress or Apparel

- [ ] (A) No Goggles, Gloves, Masks, Etc.
- [ ] (B) Unsuitable, Long Sleeves, Etc.
- [ ] (C) Shoes/Boots, Defective, Etc.

What recommendation can you make to eliminate above cause(s) of accident?

Have you communicated the accident prevention recommendations from above to other crew members and supervisors within the special district? ☐ Yes ☐ No

Did you send injured to first aid room? (If answered "Yes" we assume that you checked up to see that injured employee actually received treatment) ☐ Yes ☐ No

My signature below indicates only that I have completed this form to the best of my knowledge of the facts. Signature of Supervisor: Date:

My signature below indicates only that I have read and understand the above information, however, my signature does not necessarily indicate agreement with its contents. Signature of Employee: Date:

Comments:

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to redisclosure by the recipients and no longer be protected by federal privacy regulations.

Patient Name: Date of Birth:

Persons/organizations authorized to provide the information:

Sedgwick, P.O. Box 14493, Lexington, KY 40512-4493 is authorized to receive and use/redisclose the information in connection with my claim for worker's compensation benefits. I further authorize that a photocopy of this medical release may be used by **Sedgwick** to order and obtain medical information.

Specific description of information: complete medical record for all dates of service and all admissions including, but not limited to: history and physical exam; progress notes; office notes and letters; office chart; laboratory reports; diagnostic test reports including, but not limited to, x-ray, MRI, CT scan, bone scan, thermography reports; x-ray, MRI, CT scan, bone scan, thermography films; inpatient admissions and discharge reports; outpatient and emergency room admissions; complete hospital chart; healthcare records in your file from other providers; prescription records; operative reports; physical therapy.

The purpose of use or disclosure of patient information is for my worker's compensation claim. Patient information may be used or disclosed to administer, determine and/or litigate my claim. Patient information may be redisclosed to the parties, their agents and representatives; to the Division of Workers' Compensation; authorized Independent Medical Examiners including the Division of Labor Medical Examiners; Division of Administrative Hearings; vocational experts; entities involved in a third party action arising out of the Workers' Compensation matter, County and/or District Courts; and any of my past or present health care providers.

I understand that this authorization will expire upon the closure of my Colorado worker's compensation claim.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, revocation will not affect any actions the provider took before it received the revocation. Also, I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that I am entitled to receive a copy of this authorization.

______________________________________ ______________________________________

Signature of patient or patient's representative **Date**

Address: ____

____

If a patient's representative signs this authorization, please complete the following:

____

Printed name of patient's representative

____

Relationship to the patient

Describe the representative's authority to act for the patient:______________________________________