City of Albany
Human Resources Policy
Policy #: HR-SF-03-001
Title: Reporting On-The-Job Injuries

Safety

Purpose

This policy is meant to provide employees and management staff with the requirements for reporting on-the-job injuries.

Policy

INJURY REPORTING:

Employee Responsibilities
Every on-the-job injury regardless of its nature or extent must be reported immediately to your supervisor. There are no exceptions. The reporting procedure is the responsibility of each individual and his/her supervisor. Failure to comply with this policy may result a delay in establishing a valid worker's compensation claim and may result in disciplinary action. It may also delay the correction of an unsafe condition.

The employee completes the employee section of the "Safety Incident Report" and submits it to their supervisor prior to the end of the shift in which the incident occurred. A Worker's and Employer's Report of Occupational Injury or Disease/Illness (801) Form needs to be completed if the employee seeks medical attention. See Workers Compensation section for instructions.

Supervisor Responsibilities
The supervisor investigates the incident in order to establish what happened and if the cause of the incident can be corrected to eliminate a recurrence. The supervisor completes the "Supervisor" section of the "Safety Incident Report."

Each department determines the applicable management reviewing procedure for Safety Incident Reports.

The supervisor or their designee submits a copy of the Safety Incident Report to the Human Resources Department within 48 hours of the occurrence. The report must be complete and signed by all parties prior to submission.

If the injury results in an overnight hospital stay, the supervisor notifies the Human Resources Department within eight hours of the incident or the next business day. The department director or their designee or the Human Resources Department will notify Oregon Occupational Health and Safety Administration (OR-OSHA) within eight (8) hours if the incident results in a fatality or catastrophe (multiple injuries) and within 24 hours the incident results in an overnight hospital stay. OR-OSHA contact number 1-800-922-2689.

Safety Committee Responsibilities
The Department Safety Committee reviews all Safety Incident Reports for the prior month at their monthly committee meeting. The committee evaluates the root cause of the incident and makes recommendations to the department on how to eliminate future occurrence.

The Safety Committee Chairman will complete the safety committee section of the Safety Incident Report and return it to the appropriate supervisor for evaluation. The supervisor forwards the completed report to the Human Resources Department.

WORKERS COMPENSATION:

Worker's Report of Injury (801 Form)
If the employee is injured and needs or receives medical treatment or the injury results in time off from work, the employee must complete the Worker's Injury report immediately. This form is available on the Intranet or can be obtained from the Human Resources Department. The supervisor or their designee must complete sections #24 and #25 of the Worker's report and sign it.

Procedure for Filing 801 (When Receiving Medical Attention)
When a City employee is involved in an on-the-job incident and does not immediately need medical attention or there is no apparent injury at that time, no 801 Claim Form is filed. If at a later date an injury manifests itself as a result of the incident, the 801 form shall be completed and the injury date on the claim form will reflect the actual date of injury.

Employer's Report of Injury (801 Form)
The supervisor or their designee completes the Employer's Report of the 801 form and forwards the original Worker's and Employer's Reports within 5 days for processing.

The City has five days from the date of injury to submit the claim form to our worker's compensation carrier.

Claims Processing
When the 801 Claim Form is received by the City's worker's compensation carrier, the claim will be opened and assigned a claim number pending approval or denial which may be determined through an investigation. The City's worker's compensation carrier may investigate all claims and either approve or deny them within 90 days of receipt.

The City's workers' compensation carrier has 14 days from the date of injury to pay any time loss by the employee even though the claim approval is still pending.

An employee with an accepted workers compensation claim and who is unable to work will receive 90 days of salary continuation in lieu of time loss payments from the workers compensation carrier. After 90 days of salary continuation, the employee may be placed on an unpaid leave of absence. See specific collective bargaining agreements for union represented employee's.

The employee must notify the Human Resources Department immediately, but no later than seven (7) calendar days after being released by his/her physician of their

availability to return to work with or without restrictions. Failure to notify the Human Resources Department may result in loss of reemployment rights. Return to work medical releases with light-duty restrictions will be considered by the City. When the employee chooses not to return to work upon release for work by his/her physician or fails to notify the Human Resources Department of their availability within seven (7) calendar days of the employee's release or fails to follow reinstatement requirements, will result in the employee's discharge from the City.

Family Medical Leave will run concurrently with a work-related injury or illness time loss.

OSHA 300 Logs
Each department is required to complete an OSHA 300 log for the preceding Calendar year. The form may be accessed via the Intranet. This log incorporates applicable injuries for employees, temporary service and volunteer workers who we supervise on a day-to-day basis. The summary log (OSHA 300A) must be posted in a conspicuous place from February 1 – April 30. After posting, the form is sent to the Human Resources Department.

Temporary Service Workers
The Department of Insurance and Finance states that all employers who contract for temporary services now have the responsibility of making the appropriate entries on the OSHA 300 log when a temporary service worker is injured or develops an occupational disease. The department requests an 801 Form from the applicable Temporary Agency each time a Temporary Service Worker becomes injured or ill due to work-related causes. The department retains a copy of the Worker's report of the 801 Claim Form.

Additionally, the City will be responsible for keeping track of the days of time loss, modified work, etc., on the OSHA 300 log. However, the City only need count these days for the period of time of estimated use. For instance, the City requested a worker for a period of 14 days and the worker is injured on the fifth day of work and goes into a time loss situation, the City need only count nine days of time loss regardless of how long the worker is off after the 14th day.

Definitions

Time Loss – Results when an employee's doctor states the employee is unable to work due to an on-the-job-injury.

References

Occupational Health and Safety Administration
Refer to specific collective bargaining agreements
Safety Incident Report

Review and Authorization

Supercedes ERP No. 3.10; 2/1/1992	Created/Amended by/date LB, 10/1/2004	Effective Date 11/1/2004
HR Director	City Manager	

1. Form or worksheet revision related to this document? No ☐ Yes ☒

   If yes, attach a copy of the revised form or worksheet.

2. Training required? No ☐ Yes ☒

Safety Incident Report

Incident Report #:______________

EMPLOYEE REPORT					
Name:		Dept:			
For Fire Dept. only: Worksite Location:	☐ AFD Admin	☐ Station 11	☐ Station 12	☐ Station 13	☐ Station 14
Employment Agency Worker:	☐ Yes ☐ No	If yes, which agency:			
Job Title:		On incident date, time you began work:		☐ a.m.	☐ p.m.
When did the incident occur? Date:		Time:		☐ a.m.	☐ p.m.
When was incident reported? Date:		To Whom:			
Location and/or address of incident?					
Nature of injury/illness/illness exposure:					
Part of body affected:				☐ Left Side	☐ Right Side
Describe the injury/illness/exposure specifically (e.g., strain, sprain, cut):					
Describe the events leading up to the incident:					
What machinery/equipment were you using (if any):					
Were you properly trained for the task you were performing at the time of the incident?				☐ Yes	☐ No
Was the incident caused by defective equipment?	☐ Yes	☐ No			
If yes, explain:					
Describe what happened: **(PLEASE BE SPECIFIC)**					
What can be done to prevent this type of incident from reoccurring:					
List witness information: (address and telephone are not necessary for City of Albany employees)					
Witness #1 (Name, address, phone):					
Witness #2 (Name, address, phone):					
I choose *not* to seek medical treatment at this time. This does not preclude me from seeking medical treatment at a later date. *Signature*___________________________					
If treatment received, check one:	☐ First Aid ☐ EMT Review ☐ Urgent Care	☐ ER Room ☐ Physician or other health care provider ☐ Hospitalized as In-patient			
Date treatment received:		Dr. name and/or clinic:			
Dr./clinic address:					
Brief description of treatment (e.g., stitches, injection):					
Are you filing a worker's compensation claim at this time?	☐ Yes	☐ No			
Employee Signature:		*Date:*			

SUPERVISOR REPORT

Incident type *(check one)*:	☐ Injury ☐ Illness Exposure ☐ Illness ☐ Death	☐ Other:	

Is this incident OSHA recordable?	☐ Yes ☐ No	
Reported within 24 hours of the incident?	☐ Yes ☐ No	

# of initial hours for:	Medical treatment		Authorized time loss	

[required written note by your treating physician]

What was the most serious result for the employee?

☐ Fatality ☐ Days away from work - How many?		☐ Job transfer/restriction	☐ Other	

Categorize the immediate cause of this incident:

☐ Lack of training ☐ Supervision ☐ Rule enforcement ☐ Maintenance ☐ Other

Were safe job procedures followed?	☐ Yes ☐ No
Supervisor review of incident:	
Supervisor findings:	
Specific corrective actions or preventative measures taken:	
Was the incident caused by another person(s)?	☐ Yes ☐ No
If yes, list name(s), address(es), & phone #(s):	

Supervisor Signature:	*Date:*
Manager Signature (if applicable):	*Date:*
Department Director Signature:	*Date:*

SAFETY COMMITTEE ANALYSIS

Safety Committee findings:	
Committee recommendations:	

Safety Committee Chair Signature:	*Date:*
Human Resources Signature:	*Date:*