Hertford County
P.O. Box 116
Winton, NC 27986

TELEPHONE
252-358-7805

MEMO: To All Supervisory Personnel and Employees

FROM: Loria D. Williams, County Manager

RE: Workers Compensation

DATE: February 22, 2008

This memo is meant to clarify Hertford County policy and procedures regarding Workers Compensation issues, and to encourage all employees to file written reports related to workplace injuries as soon as possible following an injury.

(1) Any and all workplace injuries, or incidents that may have resulted in an injury that is not immediately apparent, should be reported to an employee˘ supervisor as soon as possible. A written report must be prepared on N.C. Industrial Commission Form 19 and the report should be delivered to the County Manager˘ Office as soon as possible. Supervisors shall also see that an Employee Report of Injury form and an Incident Investigation Report form are completed.

(2) Employees who sustain workplace injuries that require medical attention should inform their supervisors in advance of the need to seek medical attention, if they are reasonably able to do so without jeopardizing their health. Employees who need immediate medical attention as a result of a workplace injury should seek such attention as soon as possible, whether or not the supervisor can reasonably be informed. In either situation, the medical care provider should be informed by the employee that the injury for which treatment is being sought is job-related, and that it is a Hertford County Workers Compensation claim. The employee should not use or file a claim under their group health insurance policy for workplace injuries.

(3) An employee who has been involved in an accident or injury that does not involve missing work under physician˘ orders is not required to be cleared by a physician to return to work. If an employee desires to be cleared by a physician to return to work following a workplace injury, the employee can make such a choice, but Hertford County does not require such clearance if the employee determines that it is not necessary. An employee that has been out of work under physician˘ orders may be required by Hertford County to have physician˘ clearance to return to work, in either a limited or full capacity.

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work related injuries, illnesses, or "near miss" events (which could have caused an injury or illness) – *no matter how minor*. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

I am reporting a work related: ❑ Injury ❑ Illness ❑ Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? ❑ Yes ❑ No	
Date of injury/near miss:	Time of injury/near miss:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? ❑ Yes ❑ No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? ❑ Yes ❑ No	
If yes, when?	Supervisor:
Your signature:	Date:

Supervisor's Accident Investigation Form

Name of Injured Person _____

Date of Birth _____ Telephone Number _____

Address _____

City _____ State_____ Zip _____

(Check one) ☐ Male ☐ Female

What part of the body was injured? Describe in detail. _____

_____

What was the nature of the injury? Describe in detail. _____

_____

_____

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using? _____

_____

_____

Names of all witnesses:

_____ _____

_____ _____

Date of Event _____ Time of Event _____

Exact location of event: _____

What caused the event? _____

_____

_____

Were safety regulations in place and used? If not, what was wrong? _____

_____

Employee went to doctor/hospital? Doctor's Name _____

Hospital Name _____

Recommended preventive action to take in the future to prevent reoccurrence.

_____

_____

_____

_____ _____

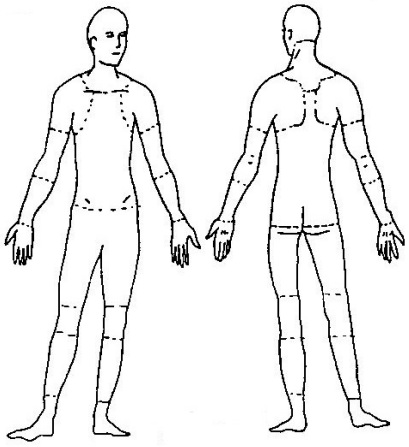
Supervisor Signature Date

Incident Investigation Report

Instructions: Complete this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness*.)

This is a report of a: ❑ Death ❑ Lost Time ❑ Dr. Visit Only ❑ First Aid Only ❑ Near Miss	
Date of incident:	This report is made by: ❑ Employee ❑ Supervisor ❑ Team ❑ Other_____

Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: ❑ Male ❑ Female	Age:
Department:	Job title at time of incident:	
Part of body affected: (shade all that apply) 	Nature of injury: (most serious one) ❑ Abrasion, scrapes ❑ Amputation ❑ Broken bone ❑ Bruise ❑ Burn (heat) ❑ Burn (chemical) ❑ Concussion (to the head) ❑ Crushing Injury ❑ Cut, laceration, puncture ❑ Hernia ❑ Illness ❑ Sprain, strain ❑ Damage to a body system: ❑ Other _____	This employee works: ❑ Regular full time ❑ Regular part time ❑ Seasonal ❑ Temporary Months with this employer Months doing this job:

Step 2: Describe the incident

Exact location of the incident:	Exact time:
What part of employee's workday? ❑ Entering or leaving work ❑ Doing normal work activities ❑ During meal period ❑ During break ❑ Working overtime ❑ Other_____	
Names of witnesses (if any):	

Number of attachments:	Written witness statements:	Photographs:	Maps / drawings:

What personal protective equipment was being used (if any)?

Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.

Description continued on attached sheets: ❑

Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)
- ❑ Inadequate guard
- ❑ Unguarded hazard
- ❑ Safety device is defective
- ❑ Tool or equipment defective
- ❑ Workstation layout is hazardous
- ❑ Unsafe lighting
- ❑ Unsafe ventilation
- ❑ Lack of needed personal protective equipment
- ❑ Lack of appropriate equipment / tools
- ❑ Unsafe clothing
- ❑ No training or insufficient training
- ❑ Other: _____

Unsafe acts by people: (Check all that apply)
- ❑ Operating without permission
- ❑ Operating at unsafe speed
- ❑ Servicing equipment that has power to it
- ❑ Making a safety device inoperative
- ❑ Using defective equipment
- ❑ Using equipment in an unapproved way
- ❑ Unsafe lifting
- ❑ Taking an unsafe position or posture
- ❑ Distraction, teasing, horseplay
- ❑ Failure to wear personal protective equipment
- ❑ Failure to use the available equipment / tools
- ❑ Other: _____

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there a reward (such as "the job can be done more quickly", or "the product is less likely to be damaged") that may have encouraged the unsafe conditions or acts? ❑ Yes ❑ No
If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? ❑ Yes ❑ No

Have there been similar incidents or near misses prior to this one? ❑ Yes ❑ No

Step 4: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

❑ Stop this activity ❑ Guard the hazard ❑ Train the employee(s) ❑ Train the supervisor(s)

❑ Redesign task steps ❑ Redesign work station ❑ Write a new policy/rule ❑ Enforce existing policy

❑ Routinely inspect for the hazard ❑ Personal Protective Equipment ❑ Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets: ❑

Step 5: Who completed and reviewed this form? (Please Print)

Written by: Department:	Title: Date:
Names of investigation team members:	
Reviewed by:	Title: Date:

CSB: 05/25/2005 Revision 1

North Carolina Industrial Commission

IC File #_____

*Emp. Code #_____

*Carrier Code #_____

Employer FEIN_____

Carrier File #_____

*Required Information.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The use of this form is required under the provisions of the Workers' Compensation Act

Employee's Name		Employer's Name	( ) - Telephone Number
Address		Employer's Address	City State Zip
City	State Zip	Insurance Carrier	Policy Number
( ) - Home Telephone	( ) - Work Telephone	Carrier's Address	City State Zip
- - Social Security Number	☐ M ☐ F Sex / / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / / ☐ A.M. ☐ P.M.
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Time employed by you (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No / Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE) O SU NÚMERO DE SEGURO SOCIAL.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
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