ACCIDENT/INCIDENT REPORT AND INVESTIGATION (JANUARY 2008)

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EXPLANATION OF FORMS

(E) Vehicle or Property Damage Reports, Injury Reports, and Supervisors Reports can be submitted electronically as long as they are routed through chain-of-command (Employee-Supervisor-Division Head-Department Head) by email. If submitted electronically, certain employee information such as Social Security numbers must be left off the report and employees may also exclude personal phone numbers and addresses if desired (however Risk Management will provide this information to insurers and others as necessary).

***** Accidents that result in bodily injuries to non-employees must be submitted in hardcopy with all required signatures.

DO NOT SUBMIT REPORTS WITH INSTRUCTIONS OR PAGES THAT ARE NOT APPLICABLE.

ACCIDENT/INCIDENT REPORTING AND INVESTIGATION INSTRUCTIONS

WHAT is to be reported?

ALL ACCIDENTS involving City employees while on duty or involving City property of any kind, including the following:

- Accidents resulting in Injury to any employee during working hours.
- Accidents resulting in Injury to any non-City employee on City property or at any area where the City is a party to an activity.
- Damage to City vehicles or property that is expected to cost over $300 in parts and labor.
- All damage to private property which has been caused or may have been caused by a City employee (or a non-City employee acting at the direction of a City employee).
- Citizen accidents with claims against the City. Refer them to the Risk Management Division.

WHERE to report?

- Contact the Division or Department Head (Supervisor, etc.).
- Contact the Police Department. All accidents involving City motorized vehicles or equipment, whether on the highways or on public or private property, must be investigated by the Police Department. It is the responsibility of the employee involved to contact the Police immediately, either by telephone or radio, and not to leave the scene of the accident until the investigation is completed, unless the accident involves injury to that employee.
- Contact the Risk Management Division within 24 hours. During office hours phone 779-7685, extension 3651 or 3650 or contact the Risk Manager at 213-3634. After hours call and leave a message on the recorder. To expedite claims, completed and signed reports should be faxed to Risk Management at 226-0123, even before they are routed to Division/Departement Heads.
- The employee's supervisor should make notification if the employee is physically unable to report promptly.
- The ranking City employee shall report the accident to Risk Management using the above procedure when an accident or damage involves a citizen or occurs on City property, or at an area where the City is a party to the activity.

WHEN to report?

- Within 24 hours to the Risk Management Division. A written report on the attached forms should be completed by the employee and receive PRIORITY TREATMENT. Insurance information must be dispatched immediately from this office. Complete and return in this report to the following in the order listed below:

    1. DIRECT SUPERVISOR. For completion of the FINAL PAGE (9) Supervisor's Report.
    2. DEPARTMENT HEAD. For review and signature. It is the Department's responsibility to copy for their records at this time.
    3. RISK MANAGEMENT DIVISION. For processing with insurance companies, etc.

HOW to fill out the report: (The employee's responsibility)

1. If Vehicle or Property Damage only is involved, the employee should fill out Pages 4, 5 and 6, VEHICLE OR PROPERTY DAMAGE, sign the report and then turn it over to his/her supervisor to complete Page 9, SUPERVISOR'S REPORT.

2. If Injury only is involved, the employee should fill out Pages 7 and 8, INJURY REPORT, sign the report and turn it over the his/her supervisor to complete Page 9, SUPERVISOR'S REPORT.

3. If both Vehicle or Property Damage and Injury are involved, the employee should fill out Pages 4 through 8 of the report, sign it and turn it over to his/her supervisor to complete Page 9, SUPERVISOR'S REPORT.

When this has been done by the employee in the time period specified, he/she has fulfilled this requirement.

It is then up to the employee's supervisor and department to complete Page 9, SUPERVISOR'S REPORT, make their departmental copies, and distribute them as designated. Remember that TIME is important in the processing of all accident reports. Insurance companies are involved and the information needs to be given out to them immediately to avoid conflicts.

With the cooperation of all concerned, we can hopefully make accidents less traumatic and become learning experiences. If you have any questions, call the Risk Management Division.

CITY OF FLAGSTAFF
RISK MANAGEMENT DIVISION
VEHICLE OR PROPERTY DAMAGE REPORT

Accident/Incident Information

Police Report Number: _____

Accident **Date**: _____ Time: _____ ☐ am. ☐ pm. Total No. Vehicles: _____

Name of Person(s) involved: _____

_____

Witness(es) include name, address, phone: _____

_____

Accident Location: _____

Report prepared by: _____

Accident/Incident Description

Describe in detail what happened. Use additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Employee Signature _____ ***Date*** _____

City Vehicle Description

Year: _____ Make/Model: _____

VIN: _____ Vehicle Tag No: _____ City I.D. No: _____

Vehicle Damage: _____

_____

City Driver Information

Name of Driver: _____ License No: _____

Home Address: _____ Home Phone No: _____

Employee's Job Title: _____ Department: _____

Date of Birth: _____ Age: _____

Other Vehicle Information

Year: _____ Make/Model: _____

VIN: _____ Vehicle Tag No. **& Year**: _____ **-** _____ State: _____

Vehicle Damage: _____

_____

Other Driver Information

Name of Driver: _____ License No: _____

Home Address: _____ Zip Code: _____

Home Phone No: _____ Other Phone: _____ Date of Birth: _____

Name of Owner: _____ Phone: _____

Owner's Address: _____

Insured by: _____

Diagram

Draw a diagram of the vehicle or equipment accident.
Use the guide below or sketch your own.

NOTE

This report will not be complete until the FINAL PAGE (Supervisor's Report) has been signed by the Supervisor, Division Head, and Department Head.

Injury Report – Employee Information

Name: _____

Mailing Address: _____ Zip Code: _____

Date of Birth: _____ Phone: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employee's department/division number: _____

Employee's job title: _____ Exact date of hire (if known): _____

Injury Report – Injury Information

Date of Injury: _____ Time of Day: _____ ☐ a.m. ☐ p.m.

Date employer notified of injury: _____

Last day of work after injury: _____ Date of return to work after injury: _____

Number of ***full*** workdays lost (do not include day of injury): _____

Address or location of accident: _____

Did the injury occur on City property: ☐ Yes ☐ No

Nature of injury (scratch, cut, etc.): _____

Part of body injured: _____

Which side injured: ☐ Right ☐ Left ☐ Both

Were you seen by a physician: ☐ Yes ☐ No

If YES, give name and/or facility: _____

Was the injured hospitalized: ☐ Yes ☐ No

IMPORTANT

IF LOST TIME IS INVOLVED, the employee should report this information to the Risk Management Division Office. When released by the physician to return to work, a Work Status/Release must be submitted so that time lost can be properly reported to the insurance company and the employee's benefits will not be delayed.

Injury Information - Continued

How did the injury happen (be specific): _____

_____

_____

_____

_____

_____

_____

Was this injury caused by lifting or handling materials: ☐ Yes ☐ No

If YES, were you using proper lifting techniques: ☐ Yes ☐ No
(bending at the knees, etc.)

Did you seek the aid of lifting devices: ☐ Yes ☐ No
(handtruck, dolly, back support devices, lifting equipment)

Did you ask your supervisor for help: ☐ Yes ☐ No

If so, was help provided to you: ☐ Yes ☐ No

If a person who is ***not*** a City employee caused to accident, give their name and address: _____

_____

_____

Were you injured while on the job? ☐ Yes ☐ No

What are your work hours: **From** _____ ☐ a.m. ☐ p.m. **To** _____ ☐ a.m. ☐ p.m.

Number of days per week you work: _____

Number of days per week your division works: _____

I am aware that it is a crime to fraudulently collect workers' compensation benefits.

Employee Signature _____ ***Date*** _____

Supervisor's Report

FOR VEHICLE OR PROPERTY DAMAGE ACCIDENTS (with or without injury), COMPLETE QUESTIONS 1 THROUGH 7.

1. In your opinion, should the vehicle shop be asked to investigate the equipment involved in the accident? ☐ Yes ☐ No

2. In your opinion, would it benefit the Accident Review Board members to visit the accident site? ☐ Yes ☐ No

3. Was training given to this employee in the use of this vehicle or equipment? ☐ Yes ☐ No

FOR INJURY-ONLY ACCIDENTS, COMPLETE QUESTIONS 4 THROUGH 7.

4. Did prior training stress the areas that were involved in the cause of the accident? ☐ Yes ☐ No

5. In your opinion, could this accident have been reasonably avoided? ☐ Yes ☐ No

6. In your opinion, what were the primary causes of this accident? (Use Page 10 as a guide).

_____

_____

7. In your opinion, what measures could be taken to see that this type of accident is eliminated in your area of supervision? _____

_____

8. Do you doubt the incident happened at work or the validity of the claim? ☐ Yes ☐ No

Comments:

_____ _____

Supervisor Signature **Date**

Comments:

_____ _____

Division Head Signature **Date**

Comments:

_____ _____

Department Head Signature **Date**

Distribution: Department Files
Risk Management Division

ACCIDENT CAUSES

UNSAFE ACTS	UNSAFE CONDITIONS
Improper work technique	Poor workstation design
Safety rule violation	Unsafe operation method
Improper PPE or PPE not used	Improper maintenance
Operating without authority	Lack of direct supervision
Failure to warn or secure	Insufficient training
Operating at improper speeds	Lack of experience
By-passing safety devices	Insufficient knowledge of job
Protective equipment not in use	Slippery conditions
Improper loading or placement	Excessive noise
Improper lifting	Inadequate guarding of hazards
Servicing machinery in motion	Defective tools/equipment
Horseplay	Poor housekeeping
Drug or alcohol use	Insufficient lighting
Insufficient rest, recovery, or sleep	

RECOMMENDATIONS:

1. Retraining assigned
2. Unsafe conditions guarded
3. Unsafe conditions corrected

CITY OF FLAGSTAFF
INFECTIOUS/COMMUNICABLE DISEASE EXPOSURE INCIDENT FORM

Exposed employee: _____ Social Security Number: _____

Job Title: _____

Department: _____ Work Phone No: _____ Home Phone No: _____

Precinct/Company/Squad: _____ Field Incident No./DR No: _____

Date of Exposure: _____ Time of Exposure: _____

Address/Location of Exposure: _____

Describe the circumstances surrounding the incident (be specific): _____

_____

_____

What were you exposed to? ☐ Blood ☐ Saliva ☐ Vomitus ☐ Vaginal Fluid ☐ Urine ☐Feces
☐ Airborne ☐Other (specify) _____

NOTE: EXPOSURE TO SWEAT DOES NOT CONSTITUTE A COMMUNICABLE DISEASE EXPOSURE

What part(s) of your body were exposed (be specific): _____

_____

Did you have any open cuts, sores, rashes that were exposed (be specific): _____

_____

List and describe all personal protective equipment you were wearing at the time of the exposure: _____

_____

_____

List all engineering and work practices (i.e., handwashing, disinfectant used) that were in place at the time of the incident:

_____

Could the incident/exposure have been avoided? If so how? _____

_____

_____

Are there any changes recommended to avoid similar future incidents? _____

_____

_____

Did you get a blood draw? ☐ Yes ☐ No Where? _____

Date and time of blood draw: _____

Who was the source of the exposure? Name of source individual: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ Phone No: _____

Supervisor's signature: _____ Date: _____

Supervisor's printed name: _____

Employee's signature: _____ Date: _____

RETURN ORIGINAL COPY TO RISK MANAGEMENT WITHIN 3 DAYS

(AUTHORIZATION TO RELEASE WORKERS COMPENSATION CHECKS TO COF. TENURED, TENURE-ELIGIBLE EMPLOYEES ONLY. REQUIRED IF EMPLOYEE IS EXPECTED TO BE OFF WORK MORE THAN 7 DAYS AND ACCEPTS CITY'S SICK INDUSTRIAL BENEFITS.)

City of Flagstaff

Date: _____ Date of Injury: _____

Claim No.: _____

SCF of Arizona
P.O. Box 33069
Phoenix, AZ 85067

SCF OF ARIZONA REPRESENTATIVE:

I hereby authorize the SCF of ARIZONA to send all compensation payments due me as a result of an on-the-job injury, until further notice is given by me and the City of Flagstaff, to:

City of Flagstaff
ATTN: Risk Management
211 W. Aspen
Flagstaff, AZ 86001

However, send my copy of any "Notice of Claim Status" to my home address.

_____ _____
Signature of Claimant Printed Name of Claimant

_____
Social Security No.

cc: Industrial Commission of Arizona

(THIS FORM IS NOT REQUIRED TO FILE FOR WORKERS COMPENSATION HOWEVER THE INSURANCE COMPANY MAY REQUIRE IT AT A LATER DATE TO COMPLETE THE PROCESS)

SCF of Arizona

Claimant: _____ Claim No.: _____

Social Security No.: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION

By this authorization or reproduction thereof, I hereby authorize any person or organization to allow SCF of Arizona or its authorized representative to examine, discuss and copy any information, records, reports and x-rays regarding my medical condition, treatment and employment history.

Date: _____ Claimant Signature : _____

Address: _____

Street City State Zip

Witnessed: _____

City of Flagstaff

Employer's Authorization Form

NOTICE TO PROVIDER: The employee has reported a work-related injury or illness to his/her supervisor, however, the claim has not yet been investigated nor reported to our industrial insurer. This form is to verify that the individual is an employee of the City of Flagstaff.

Please treat the employee as medically necessary and send all bills and appropriate medical reports to the city's industrial insurance carrier:

WORKERS COMPENSATION INSURER: SCF of ARIZONA Inc.
PO Box 33069
Phoenix AZ 85067-3069

COF POLICY NUMBER: OC2343-6
SCF TELEPHONE: 1-800-231-1363

EMPLOYEE: _____ Date of Injury: _____
(Print Full Name)

SUPERVISOR _____ Date: _____
(Signature)

AUTHORIZED PROVIDERS

CONCENTRA
120 W. Fine Ave
M-F 8am-8pm S/S 8am-4pm
773-9695; FAX 773-0208

WALK-IN MEDICAL CARE
1110 E Route 66, Ste. 100
M-F 8am-8pm S/S 10am-4pm
527-1920; FAX 527-1551

FMC Emergency Room
1200 N Beaver

779-3366; FAX 214-3637 or
773-2030