Internal Property Damage/Personal Injury Investigation Report

This report is intended to collect the detailed information required by Worker's Compensation, the City Attorney, Human Resources and/or the Internal Auditor. The information is used to determine outcomes of potential claims involving the City's liability. It should also provide you (the supervisor) the information needed to prevent the property damage or personal injury from occurring again.

Instructions:

Form I should be completed by the supervisor.
Form II should be completed by the witness(es).
Form III should be completed by the employee involved.
Authorization For Medical Treatment should be taken to medical professional if treatment is needed.
Form K-WC27-2011 should be given to injured employee.

Please do not send Form I, Form II or Form III with the employee if/when they seek medical assistance. Detach these forms, complete and forward to Human Resources (personal injury) or Internal Auditor (property damage). Feel free to attach photos, police reports or other narratives regarding the incident.

Report the occurrence by 9am of the next working day to Human Resources or Internal Auditor. Forms may be faxed to 620-341-4390.

Drug/Alcohol Testing kits are available from Human Resources. The kit consists of a DOT or Non DOT Drug Testing Custody and Control Form, Fed Ex Airbill, FedEx Clinical Envelope, a cardboard box, Collection Information Form and a sample cup. Please take a kit with you when testing.

The City of Emporia's recommended testing site is
Medical Arts Clinic of Emporia Lab
1301 W 12th St Suite 410
620-343-2900 Ext 250
Testing is available from 8:00AM-12:00PM and 1:00PM-4:00PM if testing is needed outside of these hours please visit Newman Regional Hospital Lab.

Workers Compensation Contact Information
Thomas McGee
920 Main, Suite 1700
Kansas City Mo 64105
800-423-9044

Contact Person: Sammye Strickler 800-423-9044 sstrickler@thomasmcgee.com

Please feel free to contact Human Resources (Ext. 4290) or Internal Audit (4280) with any questions or concerns.

Form I, Section A: To be completed by the supervisor

Date/Time of Incident: **Name of Supervisor:**

Date/Time Incident was Reported to Supervisor:

Description of Incident: (Be specific):

Location where the Accident/Incident Occurred and description of location (building, city, highway, etc.)

Weather conditions ☐ Clear ☐ Raining ☐ Snowing ☐ Sleeting ☐ Other, explain:

Are photos attached? ☐ Yes ☐ No

Who or What was injured or damaged? (Check applicable box and complete)

Did the occurrence involve ☐ personal injury, ☐ property damage, ☐ both, or ☐ neither (if neither skip to Section B)?

Personal Injury ☐ **Yes** ☐ **No**

Indicate the body part affected and extent of the injury:

Name of Injured:
Address:
Phone Number:

The person injured is a(n): ☐ Employee ☐ Citizen ☐ Visitor ☐ Volunteer

If Employee or Volunteer, complete this section:
Name:
Department:

Time the work day began:
Was employee seen by a medical professional? Y ☐ N ☐
If Yes: Where?____

Property Damage ☐ **Yes** ☐ **No**

What was damaged?

Where is the damaged property?

Name of Property Owner:
Owner's Address:
Owner's Telephone number:

Have similar accidents/incidents occurred in the past? Y ☐ N ☐
If yes, explain why past corrective action was not effective:

Were there any witnesses? Y ☐ N ☐ *Each witness should fill out a witness report (Form II)*
If yes, give name(s):
Police Report: Yes (report number) _______________________ No
Damage reported to Vehicle Maintenance Dept. Yes No
Should damage be paid for from department budget? Yes No

Accident/Incident Type - **For Either Bodily Injury or Property Damage**

☐ Auto Accident
☐ Caught In or Between
☐ Overexertion and/or lifting (strain)
☐ Slip/Trip/Fall (same level)
☐ Struck By or Against
☐ Sprain/Strain
☐ Property/Equipment Damage
☐ Slip/Trip/Fall (2 or more levels)
☐ Contact with Sharp Object
☐ Other – specify: ___________________
☐ Bodily Reaction (i.e. rash, etc)
☐ Repetitive Motion

Form I, Section B: To be completed by the supervisor

Causes *Check all possible causes for the incident*			
People		**Environment**	
☐	Procedures not followed or understood	☐	Poor housekeeping
☐	Using tools or equipment improperly	☐	Warning signs, lights, or horns inadequate or missing
☐	Fatigue	☐	Fire or explosion hazards
☐	Body positioned incorrectly or non-ergonomically	☐	Temperature (very hot or very cold)
☐	Rushing or working at an unsafe speed	☐	Protruding object hazard
☐	Failure to properly use equipment	☐	Slippery floor or steps
☐	Frustration or mental stress	☐	Hazardous atmospheric or other environmental hazards
☐	Removing or bypassing safety guards or devices	☐	Unsafe material placement or storage
☐	Using known defective tools or equipment	☐	Tripping hazards
☐	Job knowledge or skill deficiency	☐	Indoor air quality issues
☐	Complacency	☐	Icy conditions outside
☐	Failure to wear personal protective equipment	☐	Lighting inadequate
☐	Unprofessional behavior – Distracting, teasing, horseplay	☐	Other – specify: ________________
☐	Other – specify: ____________		
Equipment		**Procedures**	
☐	Missing or inadequate machine guards	☐	No procedures or policies in place
☐	Pinch-point or other clearance hazard	☐	Procedures wrong or incomplete
☐	Defective tools or equipment	☐	Self-inspections not performed or infrequent
☐	Tools or equipment lacking ergonomic design	☐	Hazards not identified (no Job Safety Analysis)
☐	Sharp edges	☐	No training or incomplete training
☐	Preventative maintenance not performed on equipment	☐	Training not understood or demonstrated
☐	Equipment or tools stored improperly	☐	Training not regularly reinforced
☐	Equipment safety warning system inoperative	☐	Procedures not enforced by manager
☐	Other – specify: ___________________________	☐	Other – specify:________________

Root Cause *For each cause checked above, ask **"WHY?"** the cause occurred in the first place to get to the root cause(s)*

Corrective Action
Based on the root cause(s), what have you done or plan to do to prevent a similar reoccurrence?

If an employee was involved, has he or she been drug and alcohol tested due to the property damage or bodily injury?

☐ Yes ☐ No

Form II: To be completed by witness(es). Make additional copies if necessary.

Employee Name:_________________________________ Department:_____________________________

Describe in detail what you observed.

1. Date, Time and Location where the accident/incident occurred.
2. What was the person involved doing when the accident/incident occurred?
3. Name of substance or object that directly caused the accident/incident.
4. What body part and/or property was affected?
5. Describe the injury and/or damage to property.
6. Was the person involved using all safe guards provided?
7. Did you witness any unsafe acts? Unsafe lifting, improper techniques, lack of safety equipment, horseplay, etc.
8. Were there any hazardous conditions at the time of the accident/incident? Defective tools, poor housekeeping, ice/snow, wet pavement, etc.
9. Were there any contributing factors that may have caused the accident/incident? Lack of knowledge, act of another person, etc.
10. What could have been done differently to have prevented this accident/incident?
11. Additional comments.

The statements above are true to the best of my knowledge and recollection.

Print Witness Name Witness Signature Date

EMPORIA
City of Emporia

Form III: To be completed by the employee involved. Make additional copies if necessary.

Employee Name:_________________________________ Department:_____________________________

Date of Incident:_________________________________

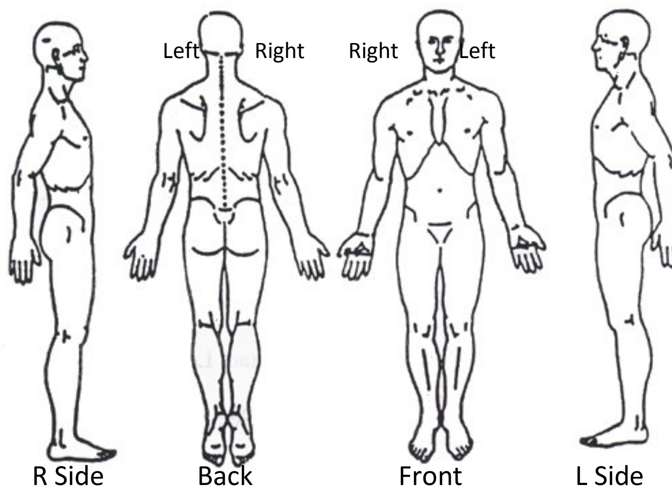
Describe in detail what occurred.

1. Location where the Personal Injury/Property Damage occurred.

2. What were you doing when the Personal Injury/Property Damage occurred?

3. Name of substance, object or conditions that directly caused the Personal Injury/Property Damage.

4. What body part and/or property was affected? (If bodily injury please note on chart below the area of injury)



5. Describe the injury and/or damage to property.

6. Were you using all safe guards/safety equipment provided?

7. Were you engaging in any unsafe acts? Unsafe lifting, improper procedure, lack of safety equipment, horseplay, etc.

8. Were there any hazardous conditions at the time of accident/incident? Defective tools, poor housekeeping, etc.

9. Were there any contributing factors that may have caused the accident/incident? Lack of knowledge, act of another person, etc.

10. What could have been done differently to have prevented this accident/incident?

11. Did you seek medical treatment? If so where?

The statements above are true to the best of my knowledge and recollection.

Print Name Sign Name Date

I have reviewed the above incident.

Supervisor's Name and Signature Date

Dept Head Name and Signature Date

Human Resources Representative/Internal Auditor Signature Date

Please forward the completed original of this report to Human Resources so it may be filed in the employees personnel file. Feel free to make a copy for your files.

Authorization For Medical Treatment

Detach and send with employee

Designated Treating Physician (8:00AM-5:00PM)

Medical Arts Clinic of Emporia Occupational Med.
1301 W 12th Ave Suite 401
Emporia, KS 66801
620-343-2900 Ext 250

After Hours or Emergency

Newman Regional Hospital E.D.
1201 W 12th Ave
Emporia, KS 66801
620-343-6810 Ext 1010

Please render necessary treatment, subject to provisions of the Workers Compensation

Act to_______________________________________, who was injured on ______________________________.
Employee Name Injury Date

Employee SSN:_____________________________ Employee Date of Birth:______________________

Report of Diagnosis

(To be completed by the treating physician)

Date of visit:_________________________

Medical Arts Clinic of Emporia

Newman Regional Hospital ED

Other facility

Nature of Injury and Diagnosis:

____

____

Was patient referred to another treatment? No Yes ____________________________
If yes, where

Please indicate the employee's work status:

Regular Duty Limited Duty No Duty

Please indicate restrictions or anticipated length of time off work

____

____

Physician's Signature: ________________________________ Date:________________________________

Detach and give to injured employee

INFORMATION FOR INJURED EMPLOYEES

K-WC 27 (Rev. 6-12)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER MAY 15, 2011 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 30 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 20 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66⅔ percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

Information for Injured Employees
K-WC 27 (Rev. 6-12)

RESPONSIBILITIES OF THE EMPLOYER

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn or shift.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

EMPLOYERS MUST PROVIDE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company: Thomas McGee, L.C
Address: 920 Main, Suite 1700
Contact Person: Sammye Strickler
Phone: 800-423-9044
Email: sstrickler@thomasmcgee.com