

CITY OF APPLETON POLICY	TITLE: ACCIDENT REPORTING AND INVESTIGATING	
ISSUE DATE: October 2002	LAST UPDATE: January 2004; May 2005; July 2008; June 2010, April 2015	SECTION: Safety
POLICY SOURCE: Human Resources Department	POLICY APPLICATION: All City Employees and Volunteers	TOTAL PAGES: 15
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I. PURPOSE

The purpose of this policy is to outline responsibilities and procedures for supervisors and employees when involved in accidents or injuries on work time, **prevent future accidents**, and to meet Federal Occupational Safety and Health Administration and State Department of Workforce Development recording requirements.

II. POLICY

The City is committed to working with its employees to provide a safe working environment **and to manage and administer claims as a result of City accidents**. In order to prevent accidents, timely and accurate accident investigation is essential. This policy provides guidelines for proper investigation. Failure to follow this policy may result in disciplinary action, up to and including discharge.

III. PROCEDURES

All City of Appleton employees and volunteers should adhere to the following procedures when an accident or injury occurs. All accidents and injuries must be immediately reported to the employee's supervisor and to the Human Resources Department. A supervisor must fully investigate the incident and work with his/her employee to complete and return an Accident Investigation Report (Exhibit A) to Human Resources within 48 hours of the accident or injury if:

- The accident involves damage to City property in excess of \$500
- There is an injury requiring medical treatment
- When the accident involves non-City employees or non-City owned property (even if there is no visible damage to the property).
- The accident occurs in the Public Right of Way.

If the accident does not meet the above criteria, the incident should be documented by completing the short Accident Reporting form (Exhibit D).

A. Motor Vehicle Accidents

1. Immediately call 911 and report the accident to your supervisor.
2. Should a supervisor have reasonable suspicion to believe the employee is under the influence of alcohol or drugs or an accident involves an injury or more than \$500 worth of damage, the supervisor should follow the procedures outlined in the City's Drug-Free Workplace policies.
3. Post Accident Testing – Employees who are involved in an accident while operating a motor vehicle or City equipment may be required to submit to testing based on the circumstances.
4. The filing of a State Accident Report is at the discretion of the Police Department, per State guidelines.

B. Injuries to a City Employee

1. When the injury occurs: the employee shall immediately notify his/her supervisor. The employee or the supervisor should also contact the Police Department if the injury is a result of a motor vehicle or domestic animal bite.
2. If immediate medical attention is needed, the employee or witness shall call 911 or Gold Cross non-emergency (920-727-3034). The employee's supervisor may also provide transportation.
3. Report Incidents to 800-321-OSHA (6742). All work-related fatalities must be reported within 8 hours. All work-related inpatient hospitalizations, amputations and loss of an eye must be reported within 24 hours. Fatalities or life-threatening injuries should be reported to the employee's department director and Human Resources (920-832-5838 or 920-832-6457) immediately.
4. If immediate medical attention is not needed, the employee may obtain treatment from his/her choice of medical providers. Employees must have a physician's authorization for time lost due to a work related injury.
5. If medical attention is sought, the employee must submit a return-to-work slip (Exhibit B) to their supervisor prior to returning to work.
6. If medical attention is not sought, the employee shall log the injury into the department's first aid log, which should be initialed by a supervisor.
7. If the incident includes a possible bloodborne pathogens exposure, refer to the City's Bloodborne Pathogen policy.
8. The City has the right to verify an injury/illness through an independent medical exam.

C. Injuries to the Public or Damage to Property Not Owned by the City of Appleton

1. All accidents resulting in an injury requiring emergency medical services to any person not employed by the City of Appleton or damage to property not owned by the City of Appleton should be immediately reported to 911, the employee's supervisor and the Human Resources Department.

2. Employees should not admit liability, discuss City operations or comment on any incident or accident involving members of the public.
3. If a citizen wishes to file a claim against the City, he/she should be directed to the City Clerk's ~~Department~~ office. The Clerk's ~~Department~~ office will forward the claim to the Human Resources Department for follow up and response to the claimant.

D. Damage to City Property or Equipment

City owned automobiles and property that are damaged by fire, theft, vandalism, etc., are considered property damage claims. All damage should be reported to the employee's supervisor immediately.

1. If vandalism or a theft loss occurs, notify the Police Department.
2. If fire occurs, notify the Fire Department.
3. Damage estimates will be required if repairs are needed.
4. If the damage is \$500 or more, the supervisor will investigate and return the completed City Accident Investigation Report (Exhibit A) to the Human Resources Department within 48 hours.
5. If the damage is under \$500, the supervisor should complete Appleton's Accident Short Form (Exhibit D) and forward a copy to the Human Resources Department.
6. Any monetary recoveries shall be reported to the Human Resources Department and sent to the Finance Department.

IV. RESPONSIBILITIES

A. The Human Resources Department is responsible for:

1. The overall coordination of the accident investigation program, including:
 - a. Monitoring and reviewing all investigations to ensure accuracy and prompt response.
 - b. Providing technical assistance to supervisors when needed.
 - c. Offering training for all individuals who conduct accident investigations.
 - d. Following up to see that recommendations made as a result of an investigation are evaluated and that an appropriate course of action is taken.

B. Each Department Director (or designee) is responsible for:

1. Ensuring that an investigation is completed for every work injury or accident that involves his/her employee(s), and reviewing all investigations to ensure accurate and prompt response.
2. Evaluating recommendations that come out of each accident investigation and taking appropriate actions to prevent future accidents.
3. Following up to see that corrective action is implemented.
4. Ensuring all departmental accident investigation forms are completed and submitted within 48 hours to Human Resources.

C. Supervisors are responsible for:

1. Promptly reporting all accidents to Human Resources. Contacting Human Resources as soon as possible if a serious accident occurs or if the employee seeks medical treatment or misses work due to an injury sustained on the job.
2. Investigating and documenting all accidents properly, including completing and submitting the City's Accident Investigation Report (Exhibit A) within 48 hours to Human Resources.
3. Working with the Human Resources Department, the employee and his/her medical provider to return the employee to work on restricted or full duty.
4. Obtaining the employee's completed Return-to-Work Slip (Exhibit B) prior to the employee returning to work. The supervisor should forward this form to Human Resources upon receipt from the employee or employee's physician.
5. Supervisors may choose to use Exhibit C to assist them when investigating an accident or injury.

D. Employees are responsible for:

1. Reporting all accidents immediately.
2. Cooperating fully with a City investigation.
3. Working with his/her supervisor to complete and submit the Accident Investigation Report (Exhibit A) to Human Resources within 48 hours of the accident or injury.
4. Providing a completed Return-to-Work slip (Exhibit B) to his/her supervisor prior to returning to work if he/she sought medical treatment or missed work due to an accident or injury sustained on the job. If the injury or accident results in an extended absence, the employee is required to keep in contact with his/her supervisor and/or HR Generalist to keep the City informed of his/her progress and anticipated treatment plan.
5. Ensuring that a supervisor initials his/her first aid log entry if the employee chooses to not seek formal medical treatment.

**REPORT INCIDENTS TO 800-321-OSHA (6742). ALL WORK-RELATED FATALITIES
MUST BE REPORTED WITHIN 8 HOURS. ALL WORK-RELATED INPATIENT HOSPITALIZATIONS,
AMPUTATIONS AND LOSS OF AN EYE MUST BE REPORTED WITHIN 24 HOURS.
THIS REPORT MUST BE SENT TO HR AND DIRECTOR WITHIN 48 HOURS. FAX TO 832-5845
ALL VEHICLE ACCIDENTS (EXCEPT FOR VALLEY TRANSIT) MUST BE SENT TO CEA. FAX TO 832-5570**

Date: _____ Incident #: _____

Date/Time Faxed to HR:

Date/Time Faxed to Dept. Director:

CITY OF APPLETON INVESTIGATION REPORT

This incident report is to be completed by a Supervisor and submitted to the Human Resources Director within 48 hours of the incident. If the employee is unable to complete his/her account of the incident, the supervisor is to provide the information, in addition to the analysis of the incident. An employee account is required.

GENERAL INFORMATION:

Name:					
Home Address		City	State	Zip	Home Telephone Number
Date and Time of Incident		Date Incident Was Reported		Department and Job Title	
Specific Location of Incident (Dept., Street, Road):					
Witness(s):					City Vehicle Number
1:		2:			
Photographs Taken by:					Were Police at Accident Scene? <input type="checkbox"/> Yes <input type="checkbox"/> No

Did the employee lose time from work due to the incident? Yes No **Last day worked:**

Did the employee receive treatment? Yes No

Facility Name: _____ **Doctor:** _____

INJURY INCIDENT

When Injury/Illness occurs on the job, Supervisors will:					
1. Determine the extent and nature of the injury/illness. See that proper first aid is administered. Activate EMS (911), if necessary.		2. In case of fatality or serious injury notify Human Resources Department immediately 832-5838 or 832-6457.		5. Complete Appleton's Investigation Report.	
3. Accompany the employee to a doctor if the employee is unable to drive or call Gold Cross Medical Transport 727-3034.		4. If not an emergency, send a return to work form with the employee.		6. Determine the cause of Incident and correct the hazard to prevent recurrence. Replenish the first aid supply after use.	
				7. Advise Human Resources Dept. when an employee returns to work. Request a doctor's release before permitting return. Be sure the employee is capable of resuming his/her work.	
Type of Injury:		<input type="checkbox"/> E. Acupuncture		Type of Incident:	
<input type="checkbox"/> A. Bruise		<input type="checkbox"/> F. Burns		<input type="checkbox"/> A. Caught between	
<input type="checkbox"/> B. Strain/Sprain		<input type="checkbox"/> G. Foreign Body		<input type="checkbox"/> B. Struck by	
<input type="checkbox"/> C. Puncture/Cut-include needle manufacturer:		<input type="checkbox"/> H. Disoriented		<input type="checkbox"/> C. Ingested/Inhaled/Inhaled	
		<input type="checkbox"/> I. Infection		<input type="checkbox"/> D. Sting/bite	
<input type="checkbox"/> D. Fracture		<input type="checkbox"/> J. Other:		<input type="checkbox"/> E. Burns	
				<input type="checkbox"/> F. Struck against	
				<input type="checkbox"/> G. Slip, trip, fall	
				<input type="checkbox"/> H. Strain, overexertion	
				<input type="checkbox"/> I. Lifting, pulling, etc.	
				<input type="checkbox"/> J. Other:	
Part of body injured:				Severity of Incident:	
<input type="checkbox"/> Arm	<input type="checkbox"/> Finger	<input type="checkbox"/> Internal	<input type="checkbox"/> Shoulder	<input type="checkbox"/> First aid only	<input type="checkbox"/> Restricted Duty
<input type="checkbox"/> Back	<input type="checkbox"/> Foot	<input type="checkbox"/> Knee	<input type="checkbox"/> Toe	<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Fatality
<input type="checkbox"/> Elbow	<input type="checkbox"/> Hand	<input type="checkbox"/> Leg	<input type="checkbox"/> Other:	<input type="checkbox"/> Lost Time	
<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Head	<input type="checkbox"/> Mouth			

EMPLOYEE'S ACCOUNT

Describe the Incident/ Include details:

Where did this occur:

When did this occur:

What were you doing just prior to the incident:

How did this incident occur:

Can the employee and/or supervisor suggest any changes to procedure or improvements to equipment that, if made, might make it less likely for a similar incident to occur in the future?

Unsafe Practice

- | | |
|---|---|
| <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Failure to use PPE properly |
| <input type="checkbox"/> Failure to warn or secure | <input type="checkbox"/> Improper loading or placement |
| <input type="checkbox"/> Operating at an improper speed | <input type="checkbox"/> Improper lifting |
| <input type="checkbox"/> Making safety devices inoperable | <input type="checkbox"/> Improper position |
| <input type="checkbox"/> Using defective equipment | <input type="checkbox"/> Servicing equipment in motion |
| <input type="checkbox"/> Using equipment improperly | <input type="checkbox"/> Inattention |
| <input type="checkbox"/> Alcohol/Drugs Suspected | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Overexertion | <input type="checkbox"/> Failure to comply with rules or procedures |
| <input type="checkbox"/> Stress/Fatigue/Attitude | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Inadequate training | |

Unsafe Condition

- | | |
|--|---|
| <input type="checkbox"/> Inadequate guards or protection | <input type="checkbox"/> Inadequate ventilation |
| <input type="checkbox"/> Defective equipment tools or material | <input type="checkbox"/> Excessive noise |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Inadequate lighting |
| <input type="checkbox"/> Inadequate warning | <input type="checkbox"/> Assault/Horseplay |
| <input type="checkbox"/> Fire/Explosion hazards | <input type="checkbox"/> Weather |
| <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Other: |

The above statement is true and correct to the best of my knowledge.

Signature: _____ Date: _____ Time: _____

SUPERVISOR ANALYSIS

1. Supervisor summary of the incident:

2. ~~What can be done to prevent this type of accident in the future?~~ **What improvements to equipment or procedures might make this type of accident less likely in the future?**

3. Were you at the accident scene: before while occurring or after the incident?

4. Describe corrective action recommended or state why corrective action is not warranted?

Unsafe Practice

- | | |
|---|---|
| <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Failure to use PPE properly |
| <input type="checkbox"/> Failure to warn or secure | <input type="checkbox"/> Improper loading or placement |
| <input type="checkbox"/> Operating at an improper speed | <input type="checkbox"/> Improper lifting |
| <input type="checkbox"/> Making safety devices inoperable | <input type="checkbox"/> Improper position |
| <input type="checkbox"/> Using defective equipment | <input type="checkbox"/> Servicing equipment in motion |
| <input type="checkbox"/> Using equipment improperly | <input type="checkbox"/> Inattention |
| <input type="checkbox"/> Alcohol/Drugs Suspected | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Overexertion | <input type="checkbox"/> Failure to comply with rules or procedures |
| <input type="checkbox"/> Stress/Fatigue/Attitude | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Inadequate training | |

Unsafe Condition

- | | |
|--|---|
| <input type="checkbox"/> Inadequate guards or protection | <input type="checkbox"/> Inadequate ventilation |
| <input type="checkbox"/> Defective equipment tools or material | <input type="checkbox"/> Excessive noise |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Inadequate lighting |
| <input type="checkbox"/> Inadequate warning | <input type="checkbox"/> Assault/Horseplay |
| <input type="checkbox"/> Fire/Explosion hazards | <input type="checkbox"/> Weather |
| <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Other: |

EMPLOYEE'S SIGNATURE: _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

REVIEWED BY DIRECTOR'S SIGNATURE: _____ DATE: _____

ACCIDENT DIAGRAM

Motor Vehicle (Complete **if** No Police Report) Personal Injury Personal Property Damage

AID FOR DIAGRAMMING: *(please check included items)*

- | | |
|---|---|
| <input type="checkbox"/> Show vehicles: <input type="checkbox"/> City "A" & <input type="checkbox"/> Other "B"
<input type="checkbox"/> Label vehicles (A & B)
<input type="checkbox"/> Label street signs/type of sign/ locations
<input type="checkbox"/> Location of accident | <input type="checkbox"/> Illustrate position of vehicles at time of collision
<input type="checkbox"/> Major reference points
<input type="checkbox"/> Location of victim/victim injuries |
|---|---|

NARRATIVE:

Witness:	Phone:		
Address:	City:	State:	Postal Code:
Witness:	Phone:		
Address:	City:	State:	Postal Code:

WITNESS REPORTING FORM

Name:

Date:

Address:

Time: AM/PM

Phone:

Interviewer:

City Employee: Yes No

Were you at the accident scene: Before accident occurred
 While accident was occurring
 After accident occurred

Who was involved in the accident?

Where did the accident happen?

When did the accident happen?

How did the accident happen? _____

Describe in detail the ~~events that occurred before the accident as you remember them~~ **accident as you observed it:**

~~In your opinion, what were the major contributing factors which caused the accident?~~

(Use back for diagram if necessary.)

PROPERTY DAMAGE INCIDENT

Instructions:

City property only

1. If over \$500, investigate and report to Human Resources Department.
2. If under \$500, complete Appleton's Accident Short Form (Exhibit D) and forward to Human Resources.

Private property involved

1. Must be investigated by Supervisor.
2. Notify Human Resources Department within 24 hours.
3. Copy of report to Human Resources Department within 48 hours.
4. Report to Department personnel responsible for claims.

Property Damaged:

City Equipment Involved (No.):

Nature of Damage:

Estimated Cost:

Owner Name:

Address:

City:

State:

Postal Code:

Phone:

Insurance Company:

INJURY/PROPERTY DAMAGE CAUSED BY ACCIDENT

Complete if No Police Report for each person claiming injury or property damage. Use a second form if necessary.

Accident involved (Check appropriate box)

- Property Damage Only
- Bodily Injury Only
- Property Damage and Bodily Injury
- Fatality
- Fatality and Property Damage
- All of the Above
- None of the Above

Were Police at Accident Scene? Yes No

Municipality: _____ Badge No: _____

Was supervisor at accident scene? Yes No

AMBULANCE REQUIRED	CLAIMED INJURIES	APPARENT INJURIES	PASSENGERS	PEDESTRIANS	OTHER VEHICLE	APPROXIMATE AGE
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INJURED PERSONS

	NAME	ADDRESS	CITY	() CHECK ONE OR MORE FOR EACH PERSON INJURED						
1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROPERTY DAMAGE TO SECOND PARTY

REGISTERED OWNER		ADDRESS		CITY		PHONE	
DRIVER		ADDRESS		CITY		PHONE	
DRIVER'S LICENSE #	LICENSE PLATE #	VEHICLE MAKE & MODEL				MODEL YEAR	
INSURANCE COMPANY		POLICY #		DESCRIPTION OF DAMAGE			

PROPERTY DAMAGE TO THIRD PARTY

REGISTERED OWNER		ADDRESS		CITY		PHONE	
DRIVER		ADDRESS		CITY		PHONE	
DRIVER'S LICENSE #	LICENSE PLATE #	VEHICLE MAKE & MODEL				MODEL YEAR	
INSURANCE COMPANY		POLICY #		DESCRIPTION OF DAMAGE			

OPERATOR'S SIGNATURE DATE

SUPERVISOR'S SIGNATURE

DATE

**ALL REPORTS FOR CITY VEHICLE ACCIDENTS (EXCEPT VALLEY TRANSIT)
MUST BE FAXED TO CEA (832-5570).**

MOTOR VEHICLE INCIDENT

Complete if No Police Report

TYPE OF ACCIDENT

Collision With	Type of Collision		Pedestrian/Bicycle Accident
<input type="checkbox"/> Other Vehicle	<input type="checkbox"/> Side Swipe	<input type="checkbox"/> Angle	<input type="checkbox"/> In Crosswalk
<input type="checkbox"/> Pedestrian	<input type="checkbox"/> Rear End	<input type="checkbox"/> Head on	<input type="checkbox"/> Near Curb
<input type="checkbox"/> City Vehicle	<input type="checkbox"/> Turn Right	<input type="checkbox"/> Broadside	<input type="checkbox"/> Mid-Block
<input type="checkbox"/> Fixed Object	<input type="checkbox"/> Turn Left	Backed up	<input type="checkbox"/> Marked Trail

VEHICLE		VEHICLE MOVEMENTS	VEHICLE	
City	Other		City	Other
<input type="checkbox"/>	<input type="checkbox"/>	Stopped		
<input type="checkbox"/>	<input type="checkbox"/>	Slowing/Stopping		
<input type="checkbox"/>	<input type="checkbox"/>	Changing Lanes		
<input type="checkbox"/>	<input type="checkbox"/>	Turning		
<input type="checkbox"/>	<input type="checkbox"/>	Pulling into curb		
<input type="checkbox"/>	<input type="checkbox"/>	Pulling away from curb		
<input type="checkbox"/>	<input type="checkbox"/>	Moving straight in its lane		
<input type="checkbox"/>	<input type="checkbox"/>	Merging		
<input type="checkbox"/>	<input type="checkbox"/>	Backing		
<input type="checkbox"/>	<input type="checkbox"/>	Parking		
<input type="checkbox"/>	<input type="checkbox"/>	Other:		
		Direction Traveled		
		Estimated speed when danger first noticed?	MPH	MPH
		Estimated speed at time of accident?	MPH	MPH
		Type of signal given by City vehicle?		
		Type of signal give by other vehicle?		
		CITY VEHICLE INVOLVED (NO.):		

TRAFFIC & ENVIRONMENTAL CONDITIONS

Traffic Controls		Weather	Street Conditions	Light	Exterior Lights
City	Other Vehicle				<input type="checkbox"/> On <input type="checkbox"/> Off
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Overcast	<input type="checkbox"/> Dry	<input type="checkbox"/> Daylight	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fair	<input type="checkbox"/> Muddy	<input type="checkbox"/> Dark	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rain	<input type="checkbox"/> Snowy/Slushy	<input type="checkbox"/> Dark w/Street lights	Interior Lights
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fog	<input type="checkbox"/> Slick/Oily	<input type="checkbox"/> Dawn	<input type="checkbox"/> On <input type="checkbox"/> Off
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Snow	<input type="checkbox"/> Wet	<input type="checkbox"/> Dusk	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sleet	<input type="checkbox"/> Icy		Warning Lights
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		<input type="checkbox"/> On <input type="checkbox"/> Off
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				

**ALL REPORTS FOR CITY VEHICLE ACCIDENTS (EXCEPT VALLEY TRANSIT)
MUST BE FAXED TO CEA (832-5570).**

Employee Return-to-Work Form

EMPLOYEE WORK RESTRICTIONS

Patient Name: _____

Current Job: _____ Part Time 1st Shift Sun. Thurs.

Physician Name (please print): _____

Phone: _____ Fax: _____

Date you saw patient: ____ - ____ - ____ Time In: _____ Injury Date: ____ - ____ - ____

Patient Description of Injury: _____

Diagnosis: _____

Treatment: _____

Full Time 2nd shift Mon Fri.
 Seasonal 3rd shift Tues Sat
 Temporary Swing Wed
 Next scheduled work day _____
 Shift _____
 Shift Supervisor: _____

Prescription strength medications ordered Yes No

Medications: _____

Plan: _____

- DISPOSITION:
1. Patient is unable to work at this time.
 2. Recommend his/her return to work with no limitations on (DATE): _____
 3. He/She may return (DATE) _____ with a daily time limitation of _____ and/or with the following limitations until _____ or until re-evaluation on _____.

A. CHECK ONLY AS RELATES TO ABOVE CONDITION

- SEDENTARY WORK.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- LIGHT WORK.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arms and/or leg controls.
- LIGHT MEDIUM WORK.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
- MEDIUM WORK.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- LIGHT HEAVY WORK.** Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
- HEAVY WORK.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

N=Never/Not Able				F=Frequent up to 30x/hr.			
O=Occasional up to 4 times/hr.				C=Constant over 30x/hr.			
Specify Restrictions for 24 day							
	N	O	F	C			
Sitting/Driving					Lab Work	Yes ___	No ___
Standing/Walking							
Climbing					X - Rays	Yes ___	No ___
Bending							
Knéeing/Squatting/Crawling							
					R	L	BIL
Reaching-Horiz./push-pull							
Reaching-Vert./above shoulder							
Gross Handling							
Finger Manipulation							
Single Grasping							
Repetitive Foot Movement							

OTHER INSTRUCTIONS AND/OR LIMITATIONS:

SCHEDULED APPOINTMENTS:

Referral Clinic _____ Date: _____ Time: _____
 Referral Clinic _____ Date: _____ Time: _____

Time Out: _____ Called Employer Date _____ Signature _____

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified on this form to my employer or his representative.

PATIENT'S SIGNATURE _____ Date _____

PHYSICIAN'S SIGNATURE _____ Date _____

ACCIDENT INVESTIGATOR'S CHECK LIST

Time _____ AM/PM Date _____

A. Arrival

- _____ 1. Make visual check to see if scene is properly protected against further accident situations.
Call Police if necessary.
- _____ 2. Treat injured.

B. Gather Evidence and Document Scene

- _____ 3. Pictures taken and evidence preserved?
- _____ Is point of impact clearly noted?
- _____ Note any property damage.
- _____ 4. Parties involved – vehicles, make, model, license number, vehicle occupants, addresses, employer?
- _____ Time of accident, exact location?
- _____ Location and cross streets.
- _____ Is your employee isolated from others? Do not allow them to discuss accident.
- _____ Witnesses names, ~~and~~ addresses **and summary of what they saw.**
- _____ Make measurements of all physical facts, including length and location of skid marks, and fixed objects.
- _____ Make a sketch of accident scene.
- _____ 5. Have Police issued citations?
- _____ Police investigators badge numbers, city, state, etc?

C. Analysis

When did it happen? _____

Where did it happen? _____

~~Why did it happen?~~ **Describe what happened?** _____

~~What caused it to happen?~~ **Where there any observable causes or contributing factors (such as weather conditions, etc)?** _____

~~Who was responsible?~~ _____

~~How could it be avoided or corrected?~~ **Are there ways a similar incident could be avoided or corrected?**

ACCIDENT REPORTING SHORT FORM

PROCEDURE:

- 1. Complete this form for all incidents which result in damage to City property estimated under \$500.
- 2. The City of Appleton Accident Investigation report (long form) should be completed for injuries that result in seeking medical attention (other than first aid), damage to City property estimated over \$500, or when there is any damage to non-City owned property.

EMPLOYEE ACCOUNT SUMMARY

Employee name:

Date/time of incident:


Vehicle #:

Location of incident:

Describe how the incident occurred:

Describe any injuries you received (if applicable).

Describe damage to City property (if applicable).

Once completed, this form should be e-mailed to your supervisor for final completion. To e-mail, click the **Microsoft Office Button  (upper left hand corner), point to **Send**, and then click **E-mail**.*


SUPERVISOR ACCOUNT SUMMARY

Name of Supervisor:

Incident # (applicable for Police personnel only):

Describe how this incident occurred.

Describe corrective action recommended or state why corrective action is not warranted.

Once completed, e-mailed to Human Resources (humanresources@appleton.org). To e-mail, click the **Microsoft Office Button  (upper left hand corner), point to **Send** and then click **E-mail** or save the document and attach to an email that you prepared.*