

<b>CITY OF APPLETON POLICY</b>	<b>TITLE: ACCIDENT REPORTING AND INVESTIGATING</b>	
ISSUE DATE: October 2002	LAST UPDATE: January 2004; May 2005; July 2008; June 2010, April 2015	SECTION: Safety
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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 ~~both the Federal Occupational Safety and Health Administration~~ **Wisconsin Department of Safety and Professional Services** and State Department of Workforce Development recording requirements.

## II. POLICY

The City is committed to working with its employees to provide a safe ~~working~~ **work** 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 **or filing a false claim** 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 **the accident reports and if applicable, any witness reports, (Exhibits A and B)** ~~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).~~

Should a supervisor have reasonable suspicion to believe that an employee is under the influence of alcohol or drugs and is involved in any motor vehicle accident, injury to themselves or others, or property/equipment damage, the supervisor should follow the procedures outlined in the City's Drug-Free Workplace policies.

**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.~~
2. 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.
3. 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, **violent act** or domestic animal bite.
2. If immediate medical attention is needed, ~~the employee or witness~~ shall call 911 or Gold Cross for non-emergencies (920-727-3034). The employee's supervisor may also provide transportation.
3. **Fatalities or life-threatening injuries should be immediately reported to the employee's Department Director and Human Resources. To contact the HR Department during normal work hours, call (920) 832-6458. Outside of normal work hours, contact either the Human Resources Director or Human Resources Deputy Director. The Human Resources Department must contact the Wisconsin Department of Safety and Professional Services within 8 hours in the event of any of the following: a) a work-related employee fatality or b) the hospitalization of 3 or more employees due to one single work-related event.**
- ~~4. 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 **C**) 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. **Supervisors should take pictures of any physical damage that was caused if possible.**
3. **Employees should not admit liability, discuss City operations or comment on any incident or accident involving members of the public.**

4. If a citizen wishes to file a claim against the City, he/she should be directed to the City Clerk's office. The Clerk's 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, **equipment** and **other** 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 a fire occurs, notify the Fire Department.
3. Supervisors should take pictures of any physical damage that was caused if possible.
4. A minimum of 2 repair estimates will be required if third party automobile repairs are needed and only if the vehicle can be driven under its own power.
5. If a third party caused damage to City property, the Human Resources Department will work with the third party's liability insurance company to recover any costs the City incurs. If a third party causes damage to City property through a criminal act, the Human Resources Department will work with the City Attorney's Office to recover the cost the City incurs. Any monetary recoveries shall be reported to the Human Resources Department and sent to the Finance Department.
- ~~6. Damage estimates will be required if repairs are needed.~~
- ~~7. 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.~~
- ~~8. 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.~~
- ~~9. 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 City 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 **proper accident reports** ~~City's Accident Investigation Report~~ (Exhibit A) within 48 hours to Human Resources.
3. **Obtaining written witness statement (Exhibit B), when applicable.**
4. Working with the Human Resources Department, the employee and his/her medical provider to return the employee to work on restricted or full duty.
5. Obtaining the employee's completed Return-to-Work Slip (Exhibit C) 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 C) 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.

## City of Appleton Incident / Accident Report Form – Employee’s Account | Exhibit A, Page 1

<b>INSTRUCTIONS: SUPERVISORS MUST SUBMIT ALL VEHICLE ACCIDENTS (EXCEPT FOR VALLEY TRANSIT) TO CEA. FAX TO 832-5570. THIS REPORT MUST ALSO BE SENT TO HR (FAX TO 832-5845) AND THE APPROPRIATE DEPARTMENT DIRECTOR WITHIN 48 HOURS.</b>			
Employee Name ( <i>Print</i> ):			
Employee ID:		Employee’s Department:	
Type of Incident / Accident: ( <i>check all that apply</i> )		<input type="checkbox"/>	Employee Injury
		<input type="checkbox"/>	City Vehicle / Equipment / Property Damage
		<input type="checkbox"/>	Injury to Public ( <i>involving City Vehicle, Property or Employee</i> )
		<input type="checkbox"/>	Public Vehicle / Equipment / Property Damage
Date and Time of Incident / Accident:			
Location of Incident / Accident:			
Witness Name(s), if applicable:			
Describe how the incident/accident occurred (if additional space is needed; use a separate page):			
Describe any injuries received by the employee or the affected public (if applicable); be specific:			
Did you (for employee injuries only) seek medical treatment? ____ Yes ____ No If “yes” response, I understand that I must provide a return to work certificate signed by my medical provider to my supervisor. _____ ( <i>initial here</i> ) Name of medical facility and doctor seen:			
Provide description of City vehicle(s) / property / equipment involved in the accident:			
Describe damage to City property (vehicles, equipment, etc.) and any damage to the affected public’s property (if applicable); be specific:			
What suggested changes do you have that, if made, might make it less likely for a similar incident / accident to occur in the future?			

**The above statement(s) are true and correct to the best of my knowledge.**

**Employee Signature:** \_\_\_\_\_

**Date and Time Signed:** \_\_\_\_\_



# City of Appleton Incident / Accident Report Form – Supervisor’s Investigation | Exhibit A, Page 2

Employee Name ( <i>Print</i> ):					
Date of Incident / Accident:					
Date Incident / Accident Reported:					
Police Incident # ( <i>if applicable</i> )					
<input type="checkbox"/>	Check here if there were witness(es) to this incident/accident. If so, obtain written witness statements ( <i>use form under Exhibit B</i> ).				
<input type="checkbox"/>	Check here if there is security or traffic camera footage of this incident/accident. If so, download this camera footage and send a copy to the Human Resources Department.				
Did employee seek medical treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Where:
Did employee lose time from work?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Last day worked:
<b>Incident / Accident Description:</b> Provide a detailed description of the incident ( <i>include any pertinent photographs, diagrams and police reports or police report numbers</i> ). Aid for diagrams (show vehicles/equipment as follows: City – “A” & Other – “B”. In addition, label street signs, location of signs and point of impact between vehicles and/or equipment. If additional space is needed; use a separate page.)					
<b>Possible Corrective Actions to Prevent Recurrence (check all that apply):</b>					
<input type="checkbox"/>	Isolate or guard the hazard	<input type="checkbox"/>	Improve lighting	<input type="checkbox"/>	Improve new employee orientation
<input type="checkbox"/>	Design out / remove hazard	<input type="checkbox"/>	Improve job briefing	<input type="checkbox"/>	Conduct more frequent inspections
<input type="checkbox"/>	New / different tools or equip	<input type="checkbox"/>	Additional training	<input type="checkbox"/>	Improve prev. maintenance program
<input type="checkbox"/>	Add signs / warning labels	<input type="checkbox"/>	Improve ventilation	<input type="checkbox"/>	Improve enforcement of procedures
<input type="checkbox"/>	Improve housekeeping	<input type="checkbox"/>	Improve lighting	<input type="checkbox"/>	Policy / procedure change
<input type="checkbox"/>	Obtain new / upgrade PPE	<input type="checkbox"/>	Other:		
<b>Describe correction action(s) recommended, if any, to prevent recurrence:</b>					
<i>What will be done?</i>		<i>Who will do it?</i>		<i>When will it be done?</i>	

Employee’s Signature \_\_\_\_\_

Date \_\_\_\_\_

Supervisor’s Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by Director’s Signature \_\_\_\_\_

Date \_\_\_\_\_



## City of Appleton Witness Reporting Form | Exhibit B

Witness Name ( <i>Print</i> ):			
Witness Address:			
Witness Phone:			
Interviewer's Name ( <i>Print</i> ):			
Date & Time of Incident/Accident:			
City Employee?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Were you at the accident scene?	<input type="checkbox"/>	Before the accident occurred.	
	<input type="checkbox"/>	While the accident was occurring.	
	<input type="checkbox"/>	After the accident occurred.	
Who was involved in the accident?			
When did the accident happen?			
How did the accident happen?			
Describe in detail the events that occurred before the accident as you remember them.			
In your opinion, what were the major contributing factors which caused the accident?			

(Use back for diagram, if necessary.)



# Employee Return-to-Work Form | Exhibit C

## EMPLOYEE WORK RESTRICTIONS

Patient Name: \_\_\_\_\_

Current Job: \_\_\_\_\_

Physician Name (please print): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date you saw patient: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Time In: \_\_\_\_\_ Injury Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Patient Description of Injury: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment: \_\_\_\_\_

Part Time ☐ 1<sup>st</sup> Shift ☐ Sun. ☐ Thurs. ☐  
Full Time ☐ 2<sup>nd</sup> Shift ☐ Mon. ☐ Fri. ☐  
Seasonal ☐ 3<sup>rd</sup> 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 \_\_\_\_\_.

## 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.

Specify Restrictions for 24 day		N	O	F	C		
Sitting/Driving						Lab Work	Yes ___ No ___
Standing/Walking						X - Rays	Yes ___ No ___
Climbing							
Bending							
Kneeling/Squatting/Crawling						R	L
Reaching-Horiz./push-pull							BIL
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 \_\_\_\_\_





**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:

<b>Name:</b> _____				
Home Address	City	Stat	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): 1. _____ 2. _____				City Vehicle Number
Photographs Taken by: _____ Were Police at Accident Scene? <input type="checkbox"/>				

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

<b><del>When Injury/Illness occurs on the job, Supervisors will:</del></b> <del>1. Determine the extent and nature of the injury/illness. See that proper first aid is administered. Activate EMS (911), if necessary.</del> <del>2. In case of fatality or serious injury notify Human Resources Department immediately 832-5838 or 832-6457.</del> <del>3. Accompany the employee to a doctor if the employee is unable to drive or call Gold Cross Medical Transport 727-3034.</del> <del>4. If not an emergency, send a return to work form with the employee.</del>				<del>5. Complete Appleton's Investigation Report.</del> <del>6. Determine the cause of Incident and correct the hazard to prevent recurrence. Replenish the first aid supply after use.</del> <del>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.</del>	
Type of Injury:		Type of Incident:			
<input type="checkbox"/> A. Bruise	<input type="checkbox"/> E. Acupuncture	<input type="checkbox"/> A. Caught between		<input type="checkbox"/> F. Struck against	
<input type="checkbox"/> B. Strain/Sprain	<input type="checkbox"/> F. Burns	<input type="checkbox"/> B. Struck by		<input type="checkbox"/> G. Slip, trip, fall	
<input type="checkbox"/> C. Puncture/Cut include needle manufacturer:	<input type="checkbox"/> G. Foreign Body	<input type="checkbox"/> C. Ingested/Inhaled/Inhaled		<input type="checkbox"/> H. Strain, overexertion	
_____	<input type="checkbox"/> H. Disoriented	<input type="checkbox"/> D. Sting/bite		<input type="checkbox"/> I. Lifting, pulling, etc.	
<input type="checkbox"/> D. Fracture	<input type="checkbox"/> I. Infection	<input type="checkbox"/> E. Burns		<input type="checkbox"/> J. Other: _____	
<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 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:                 |

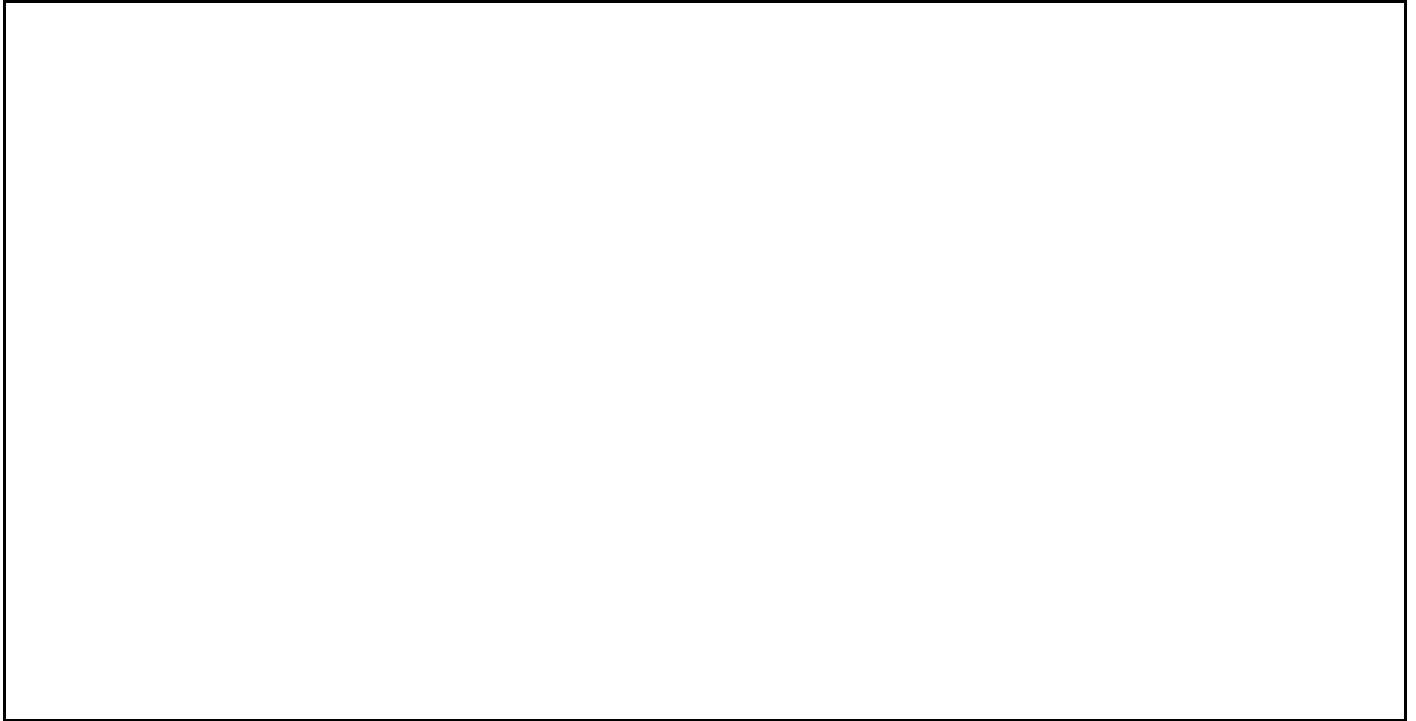
EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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)*

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

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? \_\_\_\_\_

Describe in detail the accident as you observed it:

(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 \_\_\_\_\_ Were Police at Accident Scene? ☐ Yes ☐ No

☐ Bodily Injury Only \_\_\_\_\_

☐ Property Damage and Bodily Injury \_\_\_\_\_ Municipality: \_\_\_\_\_ Badge No: \_\_\_\_\_

☐ Fatality \_\_\_\_\_

☐ Fatality and Property Damage \_\_\_\_\_ Was supervisor at accident scene? ☐ Yes ☐ No

☐ All of the Above \_\_\_\_\_

☐ None of the Above \_\_\_\_\_

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**

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

<b>VEHICLE</b>		<b>VEHICLE MOVEMENTS</b>	<b>VEHICLE</b>	
<b>City</b>	<b>Other</b>		<b>City</b>	<b>Other</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Stopped</b>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Slowing/Stopping</b>	_____MPH	_____MPH
<input type="checkbox"/>	<input type="checkbox"/>	<b>Changing Lanes</b>	_____MPH	_____MPH
<input type="checkbox"/>	<input type="checkbox"/>	<b>Turning</b>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Pulling into curb</b>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Pulling away from curb</b>	CITY VEHICLE INVOLVED (NO.): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Moving straight in its lane</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Merging</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Backing</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Parking</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Other:</b>		

**TRAFFIC & ENVIRONMENTAL CONDITIONS**

<b>Traffic Controls</b>		<b>Weather</b>	<b>Street Conditions</b>	<b>Light</b>	<b>Exterior Lights</b>
<b>City</b>	<b>Other Vehicle</b>				<input type="checkbox"/> On <input type="checkbox"/> Off
<input type="checkbox"/>	<input type="checkbox"/> Stop Sign	<input type="checkbox"/> Overcast	<input type="checkbox"/> Dry	<input type="checkbox"/> Daylight	
<input type="checkbox"/>	<input type="checkbox"/> Signal	<input type="checkbox"/> Fair	<input type="checkbox"/> Muddy	<input type="checkbox"/> Dark	
<input type="checkbox"/>	<input type="checkbox"/> Yield	<input type="checkbox"/> Rain	<input type="checkbox"/> Snowy/Slushy	<input type="checkbox"/> Dark w/Street lights	<b>Interior Lights</b>
<input type="checkbox"/>	<input type="checkbox"/> Flagman/Police Officer	<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"/> R.R. Crossing	<input type="checkbox"/> Snow	<input type="checkbox"/> Wet	<input type="checkbox"/> Dusk	
<input type="checkbox"/>	<input type="checkbox"/> Barricades	<input type="checkbox"/> Sleet	<input type="checkbox"/> Icy		<b>Warning Lights</b>
<input type="checkbox"/>	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____		<input type="checkbox"/> On <input type="checkbox"/> Off
<input type="checkbox"/>	<input type="checkbox"/> None				

**~~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 ☐ 1<sup>st</sup> 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.

OTHER INSTRUCTIONS AND/OR LIMITATIONS: \_\_\_\_\_

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					
Kneeling/Squatting/Crawling					
					R L BIL
Reaching-Horiz/push-pull					
Reaching-Vert/above shoulder					
Gross Handling					
Finger Manipulation					
Single Grasping					
Repetitive Foot Movement					

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, 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? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe what  
 happened. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Were there any observable causes or contributing factors (such as weather conditions, etc)?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are there ways a similar incident could be avoided? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 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](mailto: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.*