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 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

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.			
Employee Name *(Print)*:			
Employee ID:		Employee's Department:	
Type of Incident / Accident: *(check all that apply)*	☐	Employee Injury	
	☐	City Vehicle / Equipment / Property Damage	
	☐	Injury to Public *(involving City Vehicle, Property or Employee)*	
	☐	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. _____ *(initial here)* 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: _____

Employee Name *(Print)*:	
Date of Incident / Accident:	
Date Incident / Accident Reported:	
Police Incident # *(if applicable)*	

☐	Check here if there were witness(es) to this incident/accident. If so, obtain written witness statements *(use form under Exhibit B).*
☐	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?	☐	Yes	☐	No	Where:
Did employee lose time from work?	☐	Yes	☐	No	Last day worked:

<u>Incident / Accident Description</u>: Provide a detailed description of the incident *(include any pertinent photographs, diagrams and police reports or police report numbers)*. 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.)

Possible Corrective Actions to Prevent Recurrence (check all that apply):					
☐	Isolate or guard the hazard	☐	Improve lighting	☐	Improve new employee orientation
☐	Design out / remove hazard	☐	Improve job briefing	☐	Conduct more frequent inspections
☐	New / different tools or equip	☐	Additional training	☐	Improve prev. maintenance program
☐	Add signs / warning labels	☐	Improve ventilation	☐	Improve enforcement of procedures
☐	Improve housekeeping	☐	Improve lighting	☐	Policy / procedure change
☐	Obtain new / upgrade PPE	☐	Other:		

Describe correction action(s) recommended, if any, to prevent recurrence:		
What will be done?	*Who will do it?*	*When will it be done?*

Employee's Signature _____ **Date** _____

Supervisor's Signature _____ **Date** _____

Reviewed by Director's Signature _____ **Date** _____

City of Appleton Witness Reporting Form | Exhibit B

Witness Name *(Print)*:				
Witness Address:				
Witness Phone:				
Interviewer's Name *(Print)*:				
Date & Time of Incident/Accident:				
City Employee?	☐	Yes	☐	No
Were you at the accident scene?	☐	Before the accident occurred.		
	☐	While the accident was occurring.		
	☐	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 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: _____

_____

Prescription strength medications ordered: ☐ Yes ☐ No

Medications:_____

Plan: _____

Part Time ☐ 1st Shift ☐ Sun. ☐ Thurs. ☐
Full Time ☐ 2nd Shift ☐ Mon. ☐ Fri. ☐
Seasonal ☐ 3rd Shift ☐ Tues. ☐ Sat. ☐
Temporary ☐ Swing ☐ Wed. ☐
Next scheduled work day _____
Shift _____
Shift Supervisor _____

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.

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							

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

Exhibit A

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): 1: 2:				City Vehicle Number
Photographs Taken by:		Were Police at Accident Scene? ☐		

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.
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.
5. Complete Appleton's Investigation Report.
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:				Type of Incident:	
☐A. Bruise	☐E. Acupuncture			☐A. Caught between	☐F. Struck against
☐B. Strain/Sprain	☐F. Burns			☐B. Struck by	☐G. Slip, trip, fall
☐C. Puncture/Cut include needle manufacturer: _____	☐G. Foreign Body			☐C. Ingested/Inhaled/Inhaled	☐H. Strain, overexertion
	☐H. Disoriented			☐D. Sting/bite	☐I. Lifting, pulling, etc.
☐D. Fracture	☐I. Infection			☐E. Burns	☐J. Other:
	☐J. Other:				
Part of body injured:				Severity of Incident:	
☐Arm	☐Finger	☐Internal	☐Shoulder	☐First aid only	☐Restricted Duty
☐Back	☐Foot	☐Knee	☐Toe	☐Medical Treatment	☐Fatality
☐Elbow	☐Hand	☐Leg	☐Other:	☐Lost Time	
☐Eye(s)	☐Head	☐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

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

Unsafe Condition

- ☐ Inadequate guards or protection
- ☐ Defective equipment tools or material
- ☐ Congestion
- ☐ Inadequate warning
- ☐ Fire/Explosion hazards
- ☐ Poor housekeeping
- ☐ Inadequate ventilation
- ☐ Excessive noise
- ☐ Inadequate lighting
- ☐ Assault/Horseplay
- ☐ Weather
- ☐ 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

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

Unsafe Condition

- ☐ Inadequate guards or protection
- ☐ Defective equipment tools or material
- ☐ Congestion
- ☐ Inadequate warning
- ☐ Fire/Explosion hazards
- ☐ Poor housekeeping
- ☐ Inadequate ventilation
- ☐ Excessive noise
- ☐ Inadequate lighting
- ☐ Assault/Horseplay
- ☐ Weather
- ☐ 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

INJURED PERSONS

	NAME	ADDRESS	CITY	(☐) CHECK ONE OR MORE FOR EACH PERSON INJURED						
				AMBULANCE REQUIRED	CLAIMED INJURIES	APPARENT INJURIES	PASSENGERS	PEDESTRIANS	OTHER VEHICLE	APPROXIMATE AGE
1				☐	☐	☐	☐	☐	☐	☐
2				☐	☐	☐	☐	☐	☐	☐
3				☐	☐	☐	☐	☐	☐	☐
4				☐	☐	☐	☐	☐	☐	☐

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**
☐ Other Vehicle	☐ **Side Swipe**	☐ **Angle**	☐ **In Crosswalk**
☐ Pedestrian	☐ **Rear End**	☐ **Head on**	☐ **Near Curb**
☐ City Vehicle	☐ **Turn Right**	☐ **Broadside**	☐ **Mid-Block**
☐ Fixed Object	☐ **Turn Left**	**Backed up**	☐ **Marked Trail**

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

TRAFFIC & ENVIRONMENTAL CONDITIONS					
Traffic Controls					
City	Other Vehicle		Weather	Street Conditions	Light	Exterior Lights
☐	☐	Stop Sign	☐ Overcast	☐ Dry	☐ Daylight	☐ On ☐ Off
☐	☐	Signal	☐ Fair	☐ Muddy	☐ Dark	
☐	☐	Yield	☐ Rain	☐ Snowy/Slushy	☐ Dark w/Street lights	Interior Lights
☐	☐	Flagman/Police Officer	☐ Fog	☐ Slick/Oily	☐ Dawn	☐ On ☐ Off
☐	☐	R.R. Crossing	☐ Snow	☐ Wet	☐ Dusk	
☐	☐	Barricades	☐ Sleet	☐ Icy		Warning Lights
☐	☐	Other: ———	☐ Other: ———	☐ Other: ———		☐ On ☐ Off
☐	☐	None				

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

Exhibit B

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					
Kneeling/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 _____

Exhibit C

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? _____

Exhibit D

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.