ACCIDENT REPORTING

Any on-the-job injury, no matter how slight, must be reported by the employee to the immediate supervisor at the time of the injury. An employee does not have to report the injury in writing.

If the injury does not require professional medical care and is only a matter of applying first aid, the supervisor need only make a notation of this injury in the unit log. Any type of log the unit now maintains can be used for this purpose. In the event the unit does not maintain any type of log, then one must be established for the purpose of notating this type of injury.

If, at the request of the employee, or in the opinion of the immediate supervisor, medical attention is needed, the following procedure shall be followed:

1. If the injury occurs Monday through Friday (excluding holidays) between the hours of 8:00 a.m. and 4:30 p.m., the City's Human Resources Department will be called for authorization to obtain medical aid at the Port Huron Hospital Industrial Health Clinic. This will be done before the employee is taken for treatment.

2. If the injury occurs at any other time, the injured employee's immediate supervisor shall authorize the employee to be taken to the Port Huron Hospital Emergency Room. (NOTE: The employee must obtain authorization before seeking medical treatment.) An employee will not be denied medical aid if it is requested.

3. In the event the employee is in a "life or death" situation, the employee will be taken immediately to the Port Huron Hospital Emergency Room and the Human Resources Department notified of this fact at the earliest possible time. All other required procedures would then be followed.

4. Under no circumstances will an employee use a Blue Cross/Blue Shield Card for medical treatment, prescriptions, or medical supplies of any kind required, due to a job-related injury. Instead, the employee will either pay for the items or charge the prescriptions or medical supplies to the City of Port Huron. In either case, the receipt or bill will be turned into the employee's department immediately.

Any injury requiring medical care shall be reported to the Human Resources Department on the "Accident or Occupational Illness Report' at the earliest possible date following the accident. However, in no case shall this report be filed with the Human Resources Department later than six (6) calendar days following the accident or illness. A written statement by all witnesses will be included on the reverse side of the "Accident or Occupational Illness Report." In the event there were no witnesses, the immediate supervisor will make a statement concerning what he or she knows about the accident and any other information which might have a bearing; i.e., condition of employee's health prior to the accident, etc.

In the event the employee will lose work time as a direct result of the on-the-job injury, the employee will be carried as "sick" until the Human Resources Director has reviewed the Accident Report and determined the pay status of the employee.

Any employee failing to follow procedures listed in this regulation will be subject to disciplinary action which could include demotion, suspension or termination of employment.

This regulation supersedes:

Administrative Regulation No. 9-2, effective February 20, 1998
Administrative Regulation No. 9-2, effective January 15, 1986
Administrative Regulation No. 9-2, effective May 15, 1985

CITY OF PORT HURON ACCIDENT OR OCCUPATIONAL ILLNESS REPORT

INSTRUCTIONS: Submit original to Human Resources within six (6) working days after Employer knows case has occurred.

TYPE OR PRINT USING BLACK INK.

HUMAN RESOURCES USE ONLY
Case No. --
cc: Dept./Div.

EMPLOYEE DATA

1. Name of Employee (Last, First, Middle)		2. Social Security Number:	3. Hire Date:
4. Date of Birth: Month, Day, Year	5. Sex: [ ] Male [ ] Female	6. Home Telephone: ( )	7. Employee Number:
8. Employee's home mailing address (include city, state and zip code)			9. Dependents (enter number)
			Wife, Husband
10. Department	11. Section	12. Classification	Children under 18 years
			Other

CAUSE AND DESCRIPTION OF INJURY

13. Location or address where injury occurred (be specific):

14. Date of Injury:	15. Time of Injury : a.m. / p.m.	16. Time Shift Began: : a.m. / p.m.	17. Date of This Notice:	18. Did injury occur on Employer's premises? [ ] yes [ ] no

19. What was the employee doing just before the incident occurred? (Be specific):

20. What happened - how did the injury occur?

21. What object or substance directly harmed the employee?

22. Nature of Injury or Occupational Illness:

001		Amputation	010		Foreign body	019		Shock, fainting
002		Bruise, contusion	011		Heat exhaustion, sunstroke	020		Sprains, strains
003		Burn, scald	012		Dust diseases of lungs	021		Suffocation, drowning, strangulation
004		Concussion	013		Respiratory conditions due to toxic agent	022		Rupture, hernia
005		Cuts, open wounds	014		Internal injuries	023		Bloodborne Exposure
006		Skin disease disorders	015		Poisoning, systemic effects of toxic materials	024		Needle stick / sharps
007		Dislocation	016		Disorders caused by non-toxic materials	025		Other, specify:
008		Exposure, frostbite	017		Disorders due to repeated trauma			
009		Fracture	018		Shock, electrical			

23. Part of Body Injured or Affected (indicate right, left or both): [R] [L] [B]

040		Generalized	048		Spine	056		Elbow	064		Lower leg	080		Circulatory
041		Skull, scalp	049		Chest	057		Forearm	065		Ankle	081		Digestive
042		Eye	050		Abdomen	058		Wrist	066		Foot	082		Excretory
043		Nose	051		Back	059		Hand	067		Toe	083		Musculoskeletal
044		Mouth	052		Pelvis	060		Finger	068		Other, specify	084		Nervous
045		Jaw	053		Other trunk	061		Hip				085		Respiratory
046		Head, other	054		Shoulder	062		Thigh				086		Reproductive
047		Neck	055		Upper arm	063		Knee				087		Multiple body
												088		Skin
												089		Eyes

24. Body Systems Affected:

25. Safety equipment being worn at time of injury (gloves, hard hat, etc.):

26. Treatment of Injury:

HOSPITALIZED: [ ] Yes [ ] No

ESTIMATE OF SEVERITY			EMERGENCY CARE		
100		Minor	104		First Aid
101		Serious	105		I.H.S. Clinic
102		Critical	106		Specialist, specify in Section 27
103		Fatal, specify date of death	107		Hospital ER, specify:

27. Name and address of physician:

28. Number of days lost:

29. Last day worked:

ACCIDENT REPORT SUPPLEMENT I.

30. Injured Employee's Statement

I hereby [ ] request [ ] decline medical treatment by the City's physician

SIGNATURE OF INJURED EMPLOYEE: ✕	DATE:

31. Witness Statement

SIGNATURE OF WITNESS: ✕	DATE:

Witness Statement

SIGNATURE OF WITNESS: ✕	DATE:

THIS SECTION MUST BE COMPLETED

32. Supervisor's Statement:

In your opinion, could this accident have been prevented? [ ] yes [ ] no If yes, what can be done to prevent such accidents?

Have safety practices been put in place to prevent such an accident from occurring? [ ] yes [ ] no If yes, what practices?

If no, why not?

SIGNATURE OF [ ] SUPERVISOR [ ] FOREMAN ✕	DATE:

33. I have investigated the above report and concur with the statements made therein.
Injury time recommended: [ ] yes [ ] no

_____
DEPARTMENT HEAD SIGNATURE DATE

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34. [ ] Noted and/or [ ] Approved:

_____
HUMAN RESOURCES DIRECTOR SIGNATURE DATE

Rev 01/02

AUTHORIZATION FOR RELEASE OF INFORMATION
CITY OF PORT HURON

I hereby authorize any hospital, physician, or other person who has attended me, to furnish to the City of Port Huron any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records that could pertain to a potential work-related injury or illness that occurred on ____/_____/_____.

The release of this information will assist in the employer's determination of the employee's eligibility to receive Workers' Compensation and/or injury status eligibility.

Name _____

Signature _____
(If employee is under age 18, parent/guardian must sign)

Address _____

_____

Date _____

City of Port Huron
Human Resources Department
100 McMorran Blvd.
Port Huron, MI 48060
(810) 984-9723

Rev 01/02