ACCIDENT/INJURY QUICK REFERENCE GUIDE CHECK LIST

PLEASE FOLLOW THE STEPS BELOW TO MAKE SURE ALL THE APPROPRIATE DOCUMENTS HAVE BEEN COMPLETED AND STEPS HAVE BEEN TAKEN TO EFFICIENTLY PROCESS THIS WORK-RELATED INJURY

EMPLOYEE: _____ DATE: _____

- ☐ HAVE THE EMPLOYEE CALL COMPANY NURSE _____ AT WHICH IS AVAILABLE 24 HOURS.
- ☐ SECURE THE EMPLOYEE'S STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS FORM.
- ☐ SECURE THE SUPERVISOR'S STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS FORM.
- ☐ PROVIDE EMPLOYEE THE WORKERS' COMPENSATION CLAIM FORM (DWC-1) FOR COMPLETION, THEN COMPLETE YOUR SECTION AND MAKE A COPY FOR THE EMPLOYEE TO KEEP.
- ☐ PROVIDE EMPLOYEE WITH THE COMPLETE WRITTEN EMPLOYEE NOTIFICATION AND MPN SIGNATURE RECEIPT.
- ☐ TRANSMIT WORKERS' COMPENSATION CLAIM TO AP KEENAN THROUGH ULTRA CLAIMS ONLINE (UCO).
- ☐ PROVIDE AUTHORIZATION OF MEDICAL TREATMENT (IF APPLICABLE).
- ☐ PROVIDE DECLINATION OF MEDICAL TREATMENT (IF APPLICABLE).
- ☐ PROVIDE ANY WITNESSES WITH THE WITNESS REPORT OF INJURY (IF APPLICABLE).
- ☐ FOLLOW UP WITH EMPLOYEE FOR WORK STATUS AND DETERMINATION ON ACCOMMODATION.

SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

Name of Injured Employee: _____

Department / Location Name: _____

Position: _____ Employee Hours: _____

Date of Injury or Illness: _____Time: _____ ☐ AM ☐ PM

Was medical treatment offered? ☐ Yes ☐ No Was treatment refused? ☐ Yes ☐ No

Was employee given a DWC-1 claim form? ☐ Yes ☐ No

What type of medical treatment was given on site?

Did the injured employee leave work due to this injury or illness? ☐ No ☐ Yes, left at: _____

Has employee returned to work? ☐ Yes, date returned: _____ ☐ No, still off work

Name of person to whom the injury or illness was reported:_____

Timeliness of reporting: If the accident was not reported immediately, why not?

Location where accident or exposure occurred:

Was the injury or exposure witnessed? ☐ Yes ☐ No

If yes, please see Witness Information on next page.

WITNESS INFORMATION

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Telephone: _____ Telephone: _____

Body part injured (check all that apply and indicate left and/or right):

- ☐ Head
- ☐ Face
- ☐ Eye ☐ LT ☐ RT
- ☐ Neck
- ☐ Upper Back
- ☐ Lower Back
- ☐ Arm ☐ LT ☐ RT
- ☐ Wrist ☐ LT ☐ RT
- ☐ Finger ☐ LT ☐ RT, Which: _____
- ☐ Upper leg ☐ LT ☐ RT
- ☐ Lower leg ☐ LT ☐ RT
- ☐ Foot ☐ LT ☐ RT
- ☐ Knee ☐ LT ☐ RT
- ☐ Ankle ☐ LT ☐ RT
- ☐ Toe ☐ LT ☐ RT, Which: _____
- ☐ Other: _____

Nature of injury or illness:

- ☐ Scrape
- ☐ Cut
- ☐ Puncture
- ☐ Bruise
- ☐ Burn
- ☐ Strain/Sprain
- ☐ Foreign Body
- ☐ Poisoning
- ☐ Fracture
- ☐ Skin Disorder
- ☐ Chemical-Related
- ☐ Heat-Related
- ☐ Cold-Related
- ☐ Loss of Consciousness
- ☐ Respiratory
- ☐ Other: _____

What was employee doing at the time of injury or exposure?

Person, object or substance that directly injured employee: _____

Check any of the following unsafe actions which you feel may apply:

- ☐ Haste/Unsafe Speed
- ☐ Not Authorized
- ☐ Disregard of Instructions
- ☐ Lack of Knowledge/Skill/Training
- ☐ Failure to use Proper Equipment
- ☐ Inadequate Protective Gear
- ☐ Carelessness
- ☐ Improper Procedure
- ☐ Unsafe Equipment Usage
- ☐ Defective Equipment/Tools
- ☐ Inattention
- ☐ Assault
- ☐ Horseplay
- ☐ Alcohol/Drugs
- ☐ Unsafe Lifting
- ☐ Unsafe Position
- ☐ Running/Jumping
- ☐ Poor Housekeeping
- ☐ Act of Others
- ☐ Physical Handicap
- ☐ Other: _____

☐ I know the injury occurred on duty.

☐ I have no specific knowledge that the injury occurred on duty.

What steps have been taken or recommended to prevent a recurrence?

Comments:

Supervisor's signature: _____ Date: _____

WITNESS STATEMENT OF EMPLOYEE INJURY

WITNESS NAME: _____ CONTACT PHONE: _____

JOB TITLE: _____ DISTRICT EMPLOYEE? ☐ YES ☐ NO

HOME ADDRESS: _____

NAME(S) OF INJURED EMPLOYEES: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ ☐ AM ☐ PM

SITE AND EXACT LOCATION OF ACCIDENT: _____

1. PLEASE DESCRIBE THE ACCIDENT:

2. IN YOUR OPINION, WHAT WERE THE CONTRIBUTING CAUSES TO THE ACCIDENT?

3. PLEASE NAME ANY OTHER WITNESSES:

WITNESS SIGNATURE _____ DATE _____