City of Barre
Operations Policy

Workers Compensation
Incident Reporting, Medical Treatment & Accident Investigation Policy
8/25/2017

Purpose

This policy establishes procedures for the **mandatory** filing of an Incident Report of all work-related incidents. Reporting of all injuries or near misses can assist in the claims process should the injury get worse and it also can be used by the City of Barre Safety Committee to review near misses and improve workplace safety.

Timely first reports of incidents such as falls, muscle pulls, or back-strains, whether requiring medical attention or not, are **mandatory**. Failure to timely file a First Report for such incidents can result in employer financial penalties and may result in employee ineligibility for downstream Workers Compensation Insurance coverage as determined by the City's Workers Compensation Insurance carrier and the Vermont Department of Labor.

This policy also establishes a Designated Medical Provider for all workers' compensation injuries, in compliance with Rule 12 of the Vermont Workers' Compensation Rules.

Lastly, the policy outlines specific, **mandatory** procedures to be used in recording and following-up on work-related injuries. The Employee Incident Review Form must be used to document information regarding employee injuries for the purpose of filing workers' compensation claims and to identify loss prevention opportunities. It is incorporated into this policy by reference.

Nothing in this policy amends or changes existing collective bargaining agreements or employment contract rights, obligations or language. Rather, it is intended to enhance the City's ability to prevent injuries, manage workers' compensation claims in accordance with regulatory requirements and obtain the best medical and financial outcomes for employees who experience a work-related injury.

1. Reporting Requirement

a. Unless circumstances prevent doing so, all injuries that occur as outlined above shall be reported by the employee to the shift supervisor immediately or as soon as practical (but no later than the end of the shift).
b. These initial injury reports may be provided in writing, in person, via phone, 2-way radio or other appropriate means.
c. The employee shall participate and cooperate with the department head/supervisor in the investigation of the accident (see section III).

d. In cases where an employee voluntarily delays medical treatment or first aid for a work-related injury until sometime after the injury (including those deciding to seek treatment hours or days later), that employee shall promptly notify their immediate supervisor that treatment is desired and shall obtain treatment as outlined in section II below. The employee is **still required** to timely submit an incident report at the time of occurrence to their supervisor or the Human Resources Administrator.
e. If the employee is being kept out of work for medical reasons due to the work-related injury, they shall report their expected absence to the City and provide written documentation from the treating medical provider indicating that the individual has been directed to remain out of work.

2. Medical Treatment

a. Whenever an employee is injured that requires medical treatment, employees shall obtain evaluation and treatment from the City's designated medical provider, CVMC Express Care/ CVMC Express Care Dr. Sumner. The Employee will go to CVMC Express Care which is located at 1311 Barre-Montpelier Rd, Berlin, VT 05602. The case will then be reported to Dr. Sumners office for review.
b. In cases where **emergency medical treatment** is required, the local ambulance/EMS shall be called (or 911) and the injured employee taken to the appropriate emergency medical facility.
c. When non-emergent treatment is required outside of the designated medical provider's office hours, employees shall utilize CVMC Express Care.
d. In situations where an employee desires to see an alternate medical provider, they may do so after seeing the designated medical provider listed in this policy. A Form 8 (VT Workers' Compensation Div.) must be used.
e. In all cases where medical treatment is obtained from a healthcare provider, employees shall submit the City's Work Capabilities Form to the medical provider to complete the current work capabilities and restrictions (if any). An acceptable alternative form is the Vermont Department of Labor Form 20 or equivalent that may be used by the healthcare provider. The department head, supervisor or Human Resources will provide a copy of an appropriate form upon request.

3. Incident/Injury Review Procedures

a. Upon receiving notice of a work-related injury as described above, the department head shall complete an **Employee Incident Review Form** with the injured

employee, using the form provided by City of Barre. Paper copies of the forms will provided to all departments and they are also be available in the Employee Resource Center at the end of the hallway by the Human Resources office. The forms will also be available soon in the Employee Resource Center on the City website at www.barrecity.org under Human Resources.

b. The purpose of this form is to gather facts about the incident, its causation, witnesses, temporal information, etc. for claim filing purposes and to identify ways to **prevent future similar injuries**.
c. Care shall be taken to avoid discipline-related issues during the incident review discussion between the Department head and injured employee. Any warnings or other disciplinary actions shall take place separately from the incident review process.
d. Both the Department Head and injured employee shall sign the incident review form and attest to its accuracy.
e. The Department Head or their designee shall complete the Employee Incident Review Form with the injured employee within **24** hours. If extenuating medical circumstances prevent the employee from participating, the Department head shall complete the Employee Incident Review Form to the best of his/her ability within 24 hours of the incident, utilizing any and all information and assistance available.
f. The Employee Incident Review Form shall then be immediately forwarded to the Human Resources Administrator so the claim can be filed with VLCT.
g. All completed Employee Incident Review Forms shall be retained and reviewed by Human Resources and the Safety Committee for completeness and monitoring of corrective actions if any were suggested. In the case that an incident is going to be brought to the City's Safety Committee any personal information will be redacted.

Jean E. Mackenzie
City Manager

8/25/17
Date

City of Barre Employee Incident/Injury Review Report

This form is used to document information required by VOSHA 1904 (Recording & Reporting of Occupational Illnesses and Injuries) and Vermont Workers' Compensation Rule 3 and its subparts. The form must be completed as soon as possible, but in no case later than 24 hours after the injury occurs. As appropriate, this information is used by the city to file a workers' compensation claim.

Indicate Expected Incident Type 1st Aid☐ Med Only☐ Med with Lost Time☐	Department:		Report Completed Date
Exact Location of Incident:	Date of Incident:	Time of Incident: a.m./p.m.	Date Reported:

Work-Related Injury or Illness	**Tools and Safety Equipment**	**Other Information**
Injured Worker's Name:	Was a Machine or Tool Involved? Yes ☐ No ☐	List any witnesses below. Interview each witness individually. Signed witness statements should be maintained separately. 1. 2. 3.
Part of Body: RT/LT	If yes, was machine or tool defective? Yes ☐ No ☐	
Describe Injury/Illness:	Safety Equip/PPE Required? Yes☐ No☐ If Yes, was it used: Yes☐ No☐	
Presently, is any loss of work time expected? Yes ☐ No ☐	Was there anything the injured worker could have done to prevent the injury?	**Indicate Shift Start Time on Date of Injury:** _____
Job Title:		

Was *First Aid* Provided? Yes ☐ No ☐ If YES, by whom:

Was *Medical Treatment* provided by a healthcare provider? Yes☐ No☐
Check ☐ if from ***LIST YOUR MED PROVIDER HERE***. Provide name of medical provider IF other medical provider was used:

Describe details leading up to and including the accident/injury or manifestation of symptoms:

What conditions, circumstances or factors contributed to this incident (i.e. tools, equipment, PPE, policies, object, training, hazards, employee action/inaction, etc.)? Be thorough and descriptive!

Correction Suggestions (Note what could be done to prevent this from happening again-*being more careful is not an option*)

Who is responsible for reviewing/implementing corrective actions noted above?

Signature of Reviewing Supervisor:		Date:	
Employee Signature:		Date:	