# WORK RELATED ACCIDENT, ILLNESS OR INJURY

**PURPOSE:**
In order to comply with the Occupational Safety and Health Act, all work related accidents, illnesses and injuries, no matter how small, must be reported. Additionally, the St. Tammany Fire Protection District No. 11 Workers Compensation Insurance Carrier requires prompt reporting and investigation of all work related injuries, illnesses and accidents to determine the action necessary to prevent such injuries, illnesses and accidents from occurring in the future.  This policy included vehicle and apparatus accidents as well.

**Compliance with the procedure for reporting a work related injury is mandatory.**
Any employee who sustains a work-related injury or illness (no matter how small) should immediately (within 24 hours) report it to the chain of command as well as to the Health & Safety Officer. The injury must be recorded on a First Injury/Illness Report and/or First Report of Accident and submitted to the Health & Safety Officer. Employees who sustain an injury at work may be required to submit a drug and alcohol test in accordance to policies.

**Employees are responsible for:**

1. Having injuries and illnesses attended medically immediately if deemed necessary.  If non emergent personnel will be referred to the fire district 11 physician  (Dr. Butt – Southern Pines Medical) if it is an emergency, then the employee will be brought to most appropriate facility.  Anytime an employee is to be brought for medical evaluations, they must be accompanied by an officer or the Health & Safety Officer.

2. Reporting all injuries, illnesses and accidents to their supervisor and the Health & Safety Officer as soon as the incident happens and no later than 24 hours.

3. Assisting supervisor and management staff with the accident investigations.

4. Completing First Injury/Illness Report and/or First Report of Accident including statement by the employee on how the injury illness / accident occurred. If the injured or ill employee is unable to write a statement, the immediate supervisor will write the statement.

4. Taking a drug and alcohol test if deemed necessary.

7. Taking steps to eliminate the hazard.

**Supervisors are responsible for:**

1. Have employees attended to immediately if an emergency.

2. Contacting the Health & Safety Officer along with a Chief Officer.

3. Contacting the member's family: contacting the family will be done by the senior most on duty officer of the division. Fire Alarm may be contacted for information; however, the senior on duty officer of the injured employee will make the call to family members regarding minor accidents or injury. In the case of major illness, injury or death, the Fire Chief, Deputy Chief, family liaison and Chaplain (if available) will make notification to the family in person as soon as possible.

4. Ensuring a First Injury/Illness Report and/or First Report of Accident is completed by the employee as soon as possible, but in all cases before the end of the shift in which the accident occurred.

5. If an Accident, Injury or Illness happens during an Incident, reference the incident number in the First Injury/Illness Report and/or First Report of Accident. If the Accident, Injury or Illness happens unrelated to an incident, then the Supervisor of the employee needs to call Fire Alarm and have an incident number issued and a new report completed just for the Accident or Injury and the areas pertinent to the Accident or Injury are filled out.

6. Completing an investigation of the accident and submitting a report with the First Injury/Illness Report and/or First Report of Accident.

**The Administration is responsible for the following:**

1. During work hours, every attempt should be made to bring employees to the Southern Pines Medical if a drug screen is administered. If bringing the employee to the Southern Pines Medical is not possible, the administration is responsible for determining the next appropriate step.

2. Ensuring that appropriate documentation is complete, including incident investigations, witness statements, etc.

# ST. TAMMANY FIRE PROTECTION DISTRICT NO. 11

***Work Related Accident, Illness or Injury***

Effective: March 25, 2011
Supersedes:
Approved By: Chief Leos

## FIRST REPORT OF ACCIDENT FORM

**Employee Information – Driver of Vehicle**

Name: ______________________________

SSN: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone No.: ______________________________

Date of Birth: ______________________________

**Associated Incident Number**

Item No.: ________________

**Accident Information**

Date: ________________

Time: ________________ am / pm

Unit Involved: ____________

**Third Party Information – Driver/Owner of Vehicle**

Owner Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Vehicle: ______________________________
Year, make & model / color

Insurance Company: ______________________________

Phone No.: ________________

Date of Birth: ________________

Driver's License No.: ________________

License Plate No.: ________________

Policy No.: ________________

**Accident Description:**
*Accident Description: Briefly describe the accident. (Be Specific)*

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**Person Completing this Report:**

Name: ______________________________ Date: ____________ Phone No.: ________________

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**Location of Accident**

Did Accident occur off-site? YES NO

Location Name: ______________________________ Station: ____________

Address: ________________________________ Address: ______________________

City, State, Zip: ___________________________ City, State, Zip: __________________

**Where other employees injured?** (If so, a "First Report of Injury" from MUST be completed for each employee)
Below, please include number of injured employees and their information:

**Witness Information**

Witness 1 Name: ________________________ Witness 2 Name: ________________________

Address: ___________________________ Address: ___________________________

City, State, Zip: ________________________ City, State, Zip: ________________________

Phone No.: ___________________________ Phone No.: ___________________________

**Additional Information**

Officer: __________________________ Title: ___________ Signature: __________________

Employee: _______________________ Title: ___________ Signature: __________________

# ST. TAMMANY FIRE PROTECTION DISTRICT NO. 11

***Work Related Accident, Illness or Injury***

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## FIRST REPORT OF INJURY OR ILLNESS FORM

**Injured or Ill Employee Information**

Name: ______________________________________

SSN: _______________________________________

Address: ____________________________________

City, State, Zip: ______________________________

Phone No.: __________________________________

Date of Birth: ________________________________

**Associated Incident No.**

Item No. : ___________________

Gender.: Male Female

**Incident Information**

Date: __________________

Time: __________________ am / pm

Unit Involved: ____________

**Injury or Illness Information**

Nature of Injury or Illness: _________________________________________________

Body Location: _____________________________________

Body Part: ______________________________________

**Incident Description:**

*Incident Description: Briefly describe the incident. (Be Specific)*

**Injury or Illness Description**

Briefly describe how the injury or illness occurred

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**Location of Incident**

Did injury or illness incident occur off-site? YES NO

Location Name: ______________________________________ Station: _______________

Address: ____________________________________________ Address: _____________________________

City, State, Zip: _______________________________________ City, State, Zip: _______________________

**Witness Information**

Witness 1 Name: ______________________________ Witness 2 Name: ______________________________

Address: ____________________________________ Address: ____________________________________

City, State, Zip: ______________________________ City, State, Zip: ______________________________

Phone No.: _________________________________ Phone No.: _________________________________

**Treating Facility**

Treating Physician: ______________________________ Treating Facility: ______________________________

**Additional Information**

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|---|
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Officer: ________________________________ Title: ______________ Signature: ______________________

Employee: _____________________________ Title: ______________ Signature: ______________________

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## Investigation Report

Thoroughly describe incident/illness: (What, How, Where, Equipment, Activity, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Hospitalized or Treated, Where? (Include Address): ____________________________________

______________________________________________________________________________

Name and Address of Physician: (Include Referral): ____________________________________

______________________________________________________________________________

Did the injury require individual to perform limited duties, or to be assigned to other duties or positions?
YES or NO If yes, what duties or position?: ____________________________________

______________________________________________________________________________

And, what period of time? ______________________________________________________

Investigated by: __________________________ Title: ________________ Date: ____________

## Safety Officer's Report

What Acts, Failures to Act and/or Conditions Contributed Most Directly to This Accident or Injury? (Immediate Cause):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What Are the Basic/Fundamental Reasons for the Existence of These Acts and/or Conditions?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What Action Has or Will Be Taken to Prevent Recurrence? Place "X" By Items Completed:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Additional Notes:
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Health & Safety Officer: ______________________________________________ Date: ____________

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## WITNESS STATEMENT

Page ______ of ______

Date: _________________ Day: ________________ Time of Event: _____________ AM / PM

Incident # or detail (if applicable) __________________________________________

Name: ________________________________ Phone #: ________________________________

Address: _________________________________ City: _____________________ State: _______

D.O.B. __________________________ Age: ___________________

Statement:

_____________________________________________________________________________________
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*I make this statement of my own free will and attest that it is true and accurate to the best of my knowledge.*

Signature: _______________________________________________ Date: _______________________

Received By: ___________________________________________________ Date: __________________

Title: ___________________________________________