



**Charles County Government
Department Of
Emergency Services,
EMS Division**
Incident Reporting Form

Date: _____ **Time of Incident:** _____

Call Number (if applicable): _____

Location of Incident: _____

Parties/Personnel Involved: _____

Reference: _____

In your own words, describe below the pertinent accounts that superceded the writing of this report. You may use the space below and on the attached page, if more space is required, an additional attachment is prudent. Be sure to sign this document when it has been completed.

[Empty rectangular box for content]

Print your name/s here: _____ **Signature:** _____

Witness name/s: _____ **Signature:** _____

****For Official Use Only****
The Supervisor acknowledges that this document is typed and complete.

Supervisor Signature _____ Date _____

**CHARLES COUNTY GOVERNMENT
EMPLOYEE/SUPERVISOR REPORT OF INJURY**

| | | | |
|-------------------------------------------------------------------------------|--------------------|------------------------|--|
| NAME OF INJURED EMPLOYEE: | | SSN: | |
| HOME ADDRESS: | | | |
| HOME/CELL PHONE: | | WORK PHONE: | |
| POSITION: | DEPARTMENT: | DIVISION: | |
| DATE OF INJURY: | | TIME OF INJURY: | |
| LOCATION OF ACCIDENT/INJURY: | | | |
| DESCRIBE TYPE OF WORK BEING PERFORMED AND HOW INJURY OCCURRED: | | | |
| | | | |
| | | | |
| DESCRIBE BODILY INJURY SUSTAINED (Be specific about location on body): | | | |
| WITNESS(ES) AND PHONE NUMBERS: | | | |
| SUPERVISOR NAME: | | POSITION: | |
| AFTER INVESTIGATION, WHAT DO YOU THINK WAS THE CAUSE OF INJURY? | | | |
| | | | |
| | | | |
| RECOMMENDATION(S) FOR CORRECTIVE/PREVENTIVE MEASURES: | | | |
| | | | |

TOP MANAGEMENT REVIEW

| | | |
|---------------------------------|------------------|----------------------|
| NAME: | POSITION: | DATE: |
| NAME OF PERSON ASSIGNED: | POSITION: | PHONE NUMBER: |

This form shall be completed for all work related injuries/illnesses and forwarded to the Central Services Office with the First Report of Injury form.



Supervisor's Accident Investigation Form



Name of Injured Person _____

Date of Birth _____ Telephone Number _____

Address _____

City _____ State _____ Zip _____

(Circle one) Male Female

What part of the body was injured? Describe in detail. _____

What was the nature of the injury? Describe in detail. _____

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using? _____

Names of all witnesses:

Date of Event _____ Time of Event _____

Exact location of event: _____

What caused the event? _____

Were safety regulations in place and used? If not, what was wrong? _____

Employee went to doctor/hospital? Doctor's Name _____

Hospital Name _____

Recommended preventive action to take in the future to prevent reoccurrence.

Supervisor Signature

Date

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------|------------------|
| Number of attachments: | Written witness statements: | Photographs: | Maps / drawings: |
| What personal protective equipment was being used (if any)? | | | |
| Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details. | | | |

| Step 3: Why did the incident happen? | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Unsafe workplace conditions: (Check all that apply) Inadequate guard Unguarded hazard Safety device is defective Tool or equipment defective Workstation layout is hazardous Unsafe lighting Unsafe ventilation Lack of needed personal protective equipment Lack of appropriate equipment / tools Unsafe clothing No training or insufficient training Other: _____ | Unsafe acts by people: (Check all that apply) Operating without permission Operating at unsafe speed Servicing equipment that has power to it Making a safety device inoperative Using defective equipment Using equipment in an unapproved way Unsafe lifting Taking an unsafe position or posture Distraction, teasing, horseplay Failure to wear personal protective equipment Failure to use the available equipment / tools Other: _____ |
| Why did the unsafe conditions exist? | |
| Why did the unsafe acts occur? | |
| Is there a reward (such as “the job can be done more quickly”, or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: | |
| Were the unsafe acts or conditions reported prior to the incident? | Yes No |
| Have there been similar incidents or near misses prior to this one? | Yes No |

Step 4: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

- Stop this activity Guard the hazard Train the employee(s) Train the supervisor(s)
Redesign task steps Redesign work station Write a new policy/rule Enforce existing policy
Routinely inspect for the hazard Personal Protective Equipment Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Step 5: Who completed and reviewed this form? (Please Print)

Written by:

Title:

Department:

Date:

Names of investigation team members:

Reviewed by:

Title:

Date:



DUTY STATUS FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential or the continuing absence of your patient. It is our desire to assist our employee and your patient to return to work as soon as possible, and to assist him/her in performing essential job functions. The information you provide us is vital to us regarding the following:

- Employee’s working without risk of further injury;
- Assessing the provision of a temporary duty assignment, if necessary, that meets the employee’s needs and the needs of Charles County Government;
- Assessing the provision of any temporary, reasonable accommodations to aid the employee in performing his/her duties.

****NOTE: ATTACHED IS THE EMPLOYEE’S JOB DESCRIPTION**

| | | |
|----------------------------------------------------------------------------------------------|---------------------------------------|-------------------|
| Name: | Department: | Job Title: |
| Is this claimed as Work-Related? Yes <input type="checkbox"/> No <input type="checkbox"/> | Date of injury/illness/surgery | |

I hereby authorize my physician to complete this form:

| | |
|-------------------|--------------|
| Signature: | Date: |
|-------------------|--------------|

THE INFORMATION BELOW MUST BE COMPLETED BY THE PHYSICIAN

Work Status: Please check one of the following and provide the appropriate date:

| | |
|-------------------------------------------------------------------------------------------|--------------|
| <input type="checkbox"/> Return to regular work full time/full duty with no restrictions: | Date: |
| <input type="checkbox"/> Return to work on modified duty with noted restrictions: | Date: |
| <input type="checkbox"/> Unable to return work until: | Date: |

INDICATE ANY RESTRICTIONS (Job Description is attached)

| Activity Allowed Per Day | 0 Hours | Up to 3 Hours | Up to 4 hours | Up to 6 hours | No Restrictions | Comment |
|-----------------------------|---------|---------------|---------------|---------------|-----------------|---------|
| Sitting | | | | | | |
| Driving | | | | | | |
| Standing | | | | | | |
| Walking | | | | | | |
| Climbing | | | | | | |
| Bending/Kneeling | | | | | | |
| Reaching | | | | | | |
| Running | | | | | | |
| Pushing/Pulling _____ lbs. | | | | | | |
| Lifting/Carrying _____ lbs. | | | | | | |

OTHER RESTRICTIONS

| | |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| Can the employee drive County vehicles or operate County heavy equipment without restrictions? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Is the employee under medication that could affect the ability to work/drive? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Limit daily work to: | _____ hours/day |
| Must the employee perform sedentary work only? | Yes <input type="checkbox"/> No <input type="checkbox"/> Is yes, for how long? _____ |
| Other Recommendations and/or restrictions: | |

Has the employee met MMI (maximum medical improvement)? Yes No

Referred to another health care provider/facility? Yes No If so, where: _____

Requested Modified Work Schedule: # of hours per day: _____ # of days per week: _____

As the employee's physician, can you provide reasonable assurance that the employee's condition will not exceed (30) calendar days?

Yes No If no, provide anticipated return to full duty date: _____

PHYSICIAN ACKNOWLEDGEMENT/SIGNATURE:

I have reviewed the attached Job Description and have indicated restrictions, if any, for the above named individual.

| | |
|-------------------------------|----------------------|
| Physician Name: | Physician Signature: |
| Next Appointment Date & Time: | Date Signed: |