GENERAL ORDER

150.03

Originating From	Issue Date	Revision Date	Attachments
Administration	**11/30/1984**	**6/09/1998**	**A**

SUBJECT: **Accident Reporting – Injury/Property Damage/Loss**
APPLICABILITY: **All Personnel**

POLICY:
To ensure the effective and accurate reporting of vehicle accidents, personnel injuries and equipment loss or damage in accordance with Howard County Policy, "Risk Management Program."

1 GENERAL

1.1 New work day is defined as within 24 hours, Saturday and Sunday excluded.

1.2 Five (5) work days is defined as five (5) consecutive calendar days excluding Saturday and Sunday.

2 THE FOLLOWING SHOULD BE INCLUDED ON ALL REPORTS:

2.1 Incident number if appropriate.

2.2 If individual involved is Career or Volunteer

2.3 Social security and Career employee I.D. number if applicable.

2.4 Any corresponding report numbers (Police report number)

2.5 Investigative report should include whether or not Accident/Damage/Injury was preventable.

3 PERSONNEL INJURY

3.1 Worker's Compensation - Howard County Employee Incident/Injury Report (OSHA 301 Form- **attachment A**). Fax a copy to the Administrative Services Officer (410/313-6027) immediately. Submit the original within 24 hours through interoffice mail via the chain-of-command. If an injured employee or volunteer sought medical attention, a Doctor's Certificate must accompany the report. The Doctor's certificate must indicate if the injured may or may not return to work, and if capable of full or light duty.

3.1.1 Time Lost from Work Due to Injury:
- 3.1.1.1 Submit a Doctor's Certificate substantiating time lost.
- 3.1.1.2 Career Personnel - report time lost on daily payroll report.
- 3.1.1.3 Volunteer Personnel - submit a letter from employer indicating time and wages lost.

3.1.1.4 Submit a Doctor's Certificate indicating injured may return to work.

3.1.1.5 Extended absences from full operational status may require a fitness for duty evaluation (FIRE), as determined by the Deputy Chief of Operations.

3.1.1.6 When seeking medical care, advise the doctor or medical facility that this is a worker's compensation injury. All invoices, related reports and/or documentation should be sent to SISCO, 555 Fairmount Avenue, Baltimore, Maryland 21286.

3.1.1.7 Any invoices received by the employee should be immediately forwarded to SISCO, 555 Fairmount Avenue, Baltimore, Maryland 21286.

4 VEHICLE ACCIDENT/DAMAGE

4.1 **On Scene Vehicle/Equipment Accident Report Form** - Fax the same day to the Administrative Services Officer (410/313-6027) and submit the original the next work day.

4.1.1 Ensure that a Police Department report is made, and include the police report number on the Accident Report Form.

4.1.2 If there is damage to a County Vehicle/Equipment, a Property Loss/Damage Report must also be completed, refer to Section 5.0.

4.1.2.1 Estimates for Repairs - if to be independently repaired, submit the estimate to the Administrative Services Officer as soon as possible and wait for authorization to have the work done.

4.1.2.2 If the vehicle is going to a County shop for repairs, they will take care of getting the estimate. When using the County shop for repairs covered by insurance, they must be given the Vehicle Property Damage (VPD) claim number. This number can be obtained from the Administrative Services Officer.

4.1.2.3 When Repairs are completed notify the Administrative Services Officer. When picking up vehicle from an outside vendor, send any tickets/invoices received to the Administrative Services Officer immediately.

4.1.2.3.1 If station repairs are made and a claim is not going to be filed, indicate on the form.

4.1.2.4 All contact with insurance carriers (including accident reporting) will be conducted by the Risk Management Office, except where express authorization is granted to do otherwise.

5 VEHICLE ACCIDENT WITH EMPLOYEE INJURY

5.1 Submit all forms indicated in 2.0 and 3.0.

5.1.1 Notification of proper DFRS staff and County Officials shall be carried out in accordance with departmental policy.

5.1.2 Damage To/Loss of Equipment

5.1.2.1 Property Loss/Damage Report - must carry a Captain or Battalion Chief's signature and be submitted the next working day to the Administrative Services Officer.

5.1.2.2 Supervisor's written documentation of incident should include any pertinent information regarding the cause of the incident and what corrective action has been recommended or taken.

5.1.2.3 Estimates for Repair - submit letter indicating same including all invoices. Administrative Services Officer must authorize insurance coverage before any repairs are initiated.

5.1.2.4 If item is lost or stolen, a police report must be filed and the report number indicated on the Damage/Loss Report.

6 VERY SERIOUS AND/OR LIFE THREATENING SITUATIONS

6.1 Ensure that a staff person from the Chief's Office notifies proper County authorities.

Approved:

Joseph A. Herr
Fire Chief

SAMPLE

Location Code: _____	OSHA 300 Log Case No: _____	Claim No: _____ Risk Management Use Only

HOWARD COUNTY
EMPLOYEE INCIDENT/INJURY REPORT

INSTRUCTIONS: This form must be completed immediately for all job-related injuries or infectious material exposures. Please print and answer all questions completely. If you do not understand the questions or need help completing this form, ask your supervisor for assistance. After you have completed Section I, return the form to your supervisor to complete Section II.

Notice of employee injuries must be faxed to Risk Management (410) 313-6399) within 24 hours. Do not delay notification if information is incomplete. Call Risk Management at once if injury is serious (410) 313-6390).

SECTION I - Employee Information:

Dept: _____ **Division:** _____ **Job Title:** _____

Full Name: _____ **Male/Female Social Security #** _____

Date of Birth: _____ **Home Phone:** _____ **Work Phone:** _____

Home Address: _____
(Include Street, City, State, Zip Code)

Date of Incident: _____ **Date Hired:** _____ **Wage/Salary: $** _____

Time Employee Began Work Day: _____ **AM/PM Time of Incident:** _____ **AM/PM**

Location of Incident (Be Specific): _____

Describe in detail what happened. Include work activity being performed and what caused the incident:

_____

_____

_____

_____

Names of persons who witnessed the incident: (If not a County employee, include address and phone #)

Name: _____ **Dept:** _____ **Phone #** _____

Name: _____ **Dept:** _____ **Phone #** _____

_____

Injured Part of Body and Type of Injury? (List all that apply) _____

_____

When did you report the incident? _____ **Who did you report it to?** _____

Did you seek medical treatment? Yes / No Where were you treated? _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

This form is for Howard County internal use only; it does not constitute filing a claim with the Maryland Workers' Compensation Commission.

(Over)

SAMPLE

Section II - Supervisor Information:

Supervisor's Name: _____ **Division:** _____

Job Title: _____ **Phone:** _____ **Fax:** _____

Description of Incident (facts as you know them; do not make assumptions): _____

_____

_____

_____

List all witnesses, in addition to those listed in Section I: _____

_____

When were you informed of the incident: _____

How were you informed: _____

Was the incident the result of defective equipment or the action of non-county employees? (Please describe, preserve evidence and take photographs) _____

_____

_____

Please list what object or substance directly harmed the employee and the corrective action to prevent further incidents and expected completion dates: _____

_____

_____

What safety procedures or personal protective equipment were not in use at time of incident?

_____

_____

Has employee returned to work? Yes / No If so, when? _____

Was there any lost time from work? Yes / No If so, how long? _____

If the employee died, when did death occur? _____

SUPERVISOR'S SIGNATURE: _____ **DATE:** _____

Fax this form immediately to Risk Management (410-313-6399). Serious injuries must be called in at 410-313-6390. Send original to Risk Management: 6751 Columbia Gateway Drive, Columbia, MD, 21046. Keep a copy for Department file.

Form RM-1
Revised (1/02)