Tri-Valley CUSD #3

Accident Reporting Procedures

The following procedures are established to provide a consistent, accurate, and effective way to report employee injuries & illnesses, motor vehicle accidents, property damage, public liability, conditions that may be hazardous or dangerous, and student accidents.

Our first priority is to take care of the injured party, eliminate any immediate risk to others, report to administration and investigate the incident. If fire, explosion or other imminent danger exists, contact the nearest fire department, 911 or emergency responders as necessary.

I. Employee Injury or Illness – Worker's Compensation

A. Employee Accident Reporting

i. Please refer to the attached "Employee Responsibilities for Work Related Injuries" sheet.

B. Supervisor Reporting

i. The Supervisor shall notify administration in person or by phone as soon after any employee accident or illness has occurred.

ii. A Supervisor or designee must accompany the employee to the hospital or doctor's office or assign another person to do so.

iii. The school district is set up with _____ as their preferred medical provider to provide treatment for employees injured during their employment with the district. The Supervisor must call _____ to schedule an appointment for the injured employee to be seen.

iv. In the case of an emergency, take the employee directly to the Emergency Room at the nearest hospital.

v. **Employee Injury – (Form A) First Aid Log**

1. The Supervisor or Building Administrator may direct an employee to see the school nurse for first aid treatment or for medical treatment depending on severity of the injury. The first aid log (Form A) will be posted near all first aid kits in the school district. The first aid log (Form A) is completed by the Supervisor and when first aid treatment is provided by a nurse, their report will be attached when completed. The First Aid log is completed for all incidents of injury, which do not involve outside medical treatment. **Upon completion, this form should be forwarded to the Unit Office to keep on file.**

vi. **Employee Injury - (Form B) Administration Investigation Report**

1. If medical treatment of the injury or illness is beyond first aid, the Administration Investigation Report shall be completed by the employee's Supervisor with the affected employee(s). This form

provides all the details regarding an injury to assist with reporting to the insurance carrier and provide some basis for corrective action to prevent future injuries. **Upon completion, this form should be faxed to the Unit Office who will forward to Bushue Human Resources, Inc. to file with the workers compensation insurance carrier for the district.**

2. The Employee Responsibilities for work related injuries sheet is to be provided to any employee who is injured on the job and seeks medical treatment. **The employee's Supervisor or Building Administrator should review this information with the employee in detail.**

vii. Authorization for Medical Records and Communication Release (Form C)

1. All employees injured must sign this form authorizing release of any medical records related to work related injuries.
2. The Supervisor or Building Administrator will have the employee complete this form when they are completing the Administration Investigation Report (Form B) with them. **Upon completion, this form should be faxed to the Unit Office who will forward to Bushue Human Resources, Inc.**

viii. Referral for Treatment Form (Form D)

1. This form should be given to the injured worker that requires medical treatment. The form should be completed and signed by their treating physician and returned by the injured worker to the district after each medical treatment. **Upon receipt of a completed form, this form should be faxed to the Unit Office who will forward to Bushue Human Resources, Inc. to file with the workers compensation insurance carrier.**

ix. Employer's First Report of Injury (Form E) – Worker's Compensation

1. This is the report that will be completed by the Unit Office who will then send it to Bushue Human Resources, Inc. to report the accident to the workers' compensation carrier.

II. Motor Vehicle Accidents – (Form F)

A. **Reporting** – Any employee involved in a motor vehicle accident must immediately notify the police department and their Supervisor. Supervisors shall notify administration immediately. Administration shall be responsible for communicating information with the police department and/or media relating to the accident.

B. **Motor Vehicle Accident Form (Form F)** – This form shall be completed by the Supervisor investigating the incident and with the affected employee(s) and/ or any witnesses. This form is completed in addition to the police report as the district's internal documentation of the accident. **Upon completion, submit this paperwork**

to the Unit Office, and then the forms will be forwarded to Bushue Human Resources, Inc. to be filed with the auto insurance carrier.

C. **Vehicle Accident Kits** – All school district vehicles should have the following items in the school vehicles in case of an accident: auto ID card, camera, media card, and Motor Vehicle Accident Form (Form F).

III. Property Damage – (Form G)

A. **Reporting** - If there is damage to district property (including grounds, equipment, buildings, or others property or equipment), employees shall notify their immediate Supervisor and the Building Principal.

B. **Property Damage Form (Form G)** – This form shall be completed by the Building Administrator investigating the incident with the affected employee(s) and/or any witnesses. **Upon completion, submit this paperwork to the Unit Office, and then the forms will be forwarded to Bushue Human Resources, Inc. to be filed with the property insurance carrier.**

IV. Public Liability – (Form H)

A. **Reporting** - If an injury or illness occurs to anyone who is a non-district employee, immediately notify a Supervisor and/or Administration.

B. **Public Liability Form (Form H)** – This form shall be completed by any Supervisor attending to the injured party. This includes injury/illness to any visitors to school facilities or activities whether on or off school premises. **Once Form H is completed, submit this paperwork to the Unit Office, and then the forms will be forwarded to Bushue Human Resources, Inc. to be filed with the general liability insurance carrier.**

V. Hazardous or Dangerous Conditions – (Form I)

A. **Reporting** – Any employee, visitor, or Supervisor may report a hazardous or dangerous condition that might put an employee, visitor or the district at risk.

B. **The Unsafe Practices & Hazardous Conditions Report – (Form I)** – This form is completed when employees or Supervisors recognize a potentially hazardous or dangerous condition to evaluate the condition and plans for improvement.

VI. Student Injury/Illness – (Form J)

A. **Reporting** – Students, Parents, Volunteers & District Employees are to be provided with information to notify a Supervisor any time a student is injured on school premises or during school activities.

B. **Student Accident Report – (Form J)** - In the event of a student being injured during the school day or at any school event, the district employee present at the time of the accident is responsible for ensuring proper care to the student and notifying the student's legal guardian. The Supervisor is responsible for notifying a member of administration of the accident and completing the Student Accident Report form

along with the nurse's report. **Once Form J is completed, submit this paperwork to the Unit Office, and then the forms will be forwarded to Bushue Human Resources, Inc. to be filed with the student accident insurance carrier.**

VII. Record-keeping

A. The designated administrative staff shall maintain forms and files related to the reports as noted above throughout the school year. A regular review of claims and trends shall be completed and files shall be audited annually.

Attached forms:

Form A – First Aid Log
Form B – Administration Investigation Report
Form C – Authorization for Medical Records & Communication Release
Form D – Referral for Treatment Form
Form E – Employer's First Report of Injury
Form F – Motor Vehicle Accident
Form G – Property Damage
Form H – Public Liability
Form I – Unsafe Practices & Hazardous Conditions Report
Form J – Student Accident Report

Tri-Valley CUSD #3

First Aid Log
FORM A

Date of Injury:	/ /	**Time of Injury:**	☐ A.M. ☐ P.M.
Employee's Name:			
Location:			
Job Title:			
Describe Injury:			
Describe How Injury Occurred:			

Was First Aid Provided? ☐ Yes ☐ No

Describe the First Aid Treatment:	
Person Rendering First Aid Treatment:	

Witnesses

Name:		**Name:**	
Phone #:		**Phone #:**	
Position:		**Position:**	
Statement:		**Statement:**	

Supervisor Signature:	
Employee Signature:	
Date Form Completed	

Tri-Valley CUSD #3

Administration Investigation Report
FORM B

Employee Information			
Employee's Name:			
Date of Birth:	/ /	Date of Hire:	/ /
Job Title:		Department:	

Accident Details			
Date of Injury:	/ /	Time of Injury	☐ A.M. ☐ P.M.
Location:		Scheduled Hours:	From: To:
Weather Conditions:		Temperature:	
Please provide a Summary of the Accident:			
Body part(s) injured:			
Nature of Injury:			
What Job was being done at the time of the incident:			
Who else was involved:			
What machine, equipment, or object directly caused the injury:			
What PPE or Safety Equipment was in use:			
What safety rules/OSHA rules or procedures were violated:			
Has the employee had this accident/ incident before:	☐ Yes ☐ No If yes, when:		

Witnesses			
Name:		Name:	
Phone #:		Phone #:	
Position:		Position:	
Corrective Action / Follow-Up			
Was there anything that could have been done to prevent this accident/injury/ incident:	☐ Yes ☐ No		
What Corrective Action or Follow-Up Action was taken:			
When:			
Was an all employee discussion of this accident conducted:	☐ Yes ☐ No		
If yes, by whom:			
Did the Supervisor/Safety Committee review this incident:	☐ Yes ☐ No		
If yes, what was recommended:			

Supervisor Signature:	
Employee Signature:	
Date Form Completed	

Tri-Valley CUSD #3

Authorization for Medical Records and Communication Release FORM C

By this form, or copy thereof, I, _____,

authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, a third party claim administrator hired by the district and/or the district's insurance provider, or any representative of Bushue Human Resources, Inc., as to my care and treatment and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I also authorize any treating physician or medical provider to review any additional medical records provided to them.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Patient Name_____ Patient Signature_____

Date Signed _____

Patient Address_____
Street City State Zip Code

Employer Name_____

Employer Contact_____
Name Phone Number

Bushue Human Resources, Inc., 104 N. Second Street, PO Box 89, Effingham, IL 62401
(217) 342-3046 FAX (217) 342-5673

Tri-Valley CUSD #3

Referral for Treatment Form
FORM D

Tri-Valley CUSD #3 has referred _____
(Employee name)

to be seen and treated on _____.
(Date)

Date of Injury: _____ Time of Injury: _____

Physician: Complete and Return this Portion to Employee

Employer:	**Tri-Valley CUSD #3**
Employee Name:	
Nature of Injury:	
Medical Diagnosis:	
Work Status	☐ **May return to work on:** ☐ **No restrictions/Full duty** ☐ **Unable to return to work. Re-evaluation on:**
Restrictions (be specific), if any?	
Recommended Treatment:	☐ **MRI** ☐ **CAT scan** ☐ **Physical Therapy** ☐ **Surgical Treatment** ☐ **Injections** ☐ **Other (s)** **Please provide details of recommended treatment:**
Next Appointment:	
Physician Name:	
Address:	
Phone Number:	

Physician Signature: _____ Date: _____

Tri-Valley CUSD #3

Employee Responsibilities
For Work Related Injuries

The District has implemented policies and procedures in order to ensure a rapid return to work following a work related accident. If you should become injured during working hours please follow the instructions as outlined below:

Report all injuries to your immediate supervisor immediately. All injuries/incidents are to be reported regardless of how insignificant the injury may appear.

Should you require medical attention for a work related injury, we ask that you use the preferred medical provider that is set up for the district **Provider Name and Address.** This medical provider has agreed to provide immediate medical treatment for the benefit of our employees who are injured at work.

If you incur medical bills, notify the treating medical facility to send the bills directly to the school district, **Attn: Karen Ijams.** Provide the District with a doctor's note following each doctor's visit.

Cooperate with the District in completing the accident report form and conducting the accident investigation to ensure the accident can be turned into the insurance company in a timely manner.

If a work related injury requires you to miss work you will need to provide your immediate supervisor a medical release from your doctor. The District will attempt to work with your doctor to make alternative duty/work available where possible.

When you return to work, you must provide your immediate supervisor with a written release to return to work from your doctor. You should contact your immediate supervisor as soon as you know that you will be returning to work, so that you can be rescheduled for work.

Follow up weekly and/or following each doctor's visit with the District and the insurance company claim adjuster on the status of your treatment and your recovery. Should you have any questions/concerns about the handling of your workers compensation benefits please contact the unit office and let them assist you with your questions/concerns.

If you are released from work, workers compensation will pay your lost wages. The first 3 days of lost time after an injury are not compensable. Compensation is payable beginning on your 4th day of lost time. If your disability extends beyond 14 calendar days, the first 3 days of lost time will be paid retroactively. Your compensation is based on the average of 52 weeks of wages prior to your last day worked and the compensation benefit is paid at a 66 2/3 percent of the average weekly wage (subject to state max/minimums). Compensation benefits are non taxable. In most cases, the first lost wage-disability payment will be received within 30 days from the insurance company. If payment takes longer, you should contact the Administrative office or the insurance company.

Please Note, just because an accident happens at work it does not always mean it will be considered a work related accident. The Worker's Compensation Carrier always makes the determination regarding coverage of the claim.

FORM E

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY Please type or print.

Employer's FEIN 376004009	Date of report	Case or File #	Is this a lost workday case? ☐ Yes ☐ No
Employer's name Tri-Valley CUSD #3		Doing business as	
Employer's mailing address 410 E. Washington St., Downs, IL 61736			
Nature of business or service **School District**		SIC code **8211**	
Name of workers' compensation carrier/admin. State National	Policy/Contract # NFA 0857042		Self-insured? **No**
Employee's full name		Social Security #	Birthdate
Employee's mailing address			
Employee's telephone number		Employee's e-mail address	
☐ Male ☐ Female	☐ Married ☐ Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? ☐ Yes ☐ No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? ☐ Yes ☐ No		Was the employee hospitalized overnight as an inpatient? ☐ Yes ☐ No	
Report prepared by	Signature	Title and telephone #	

Please send this form to the ILLINOIS INDUSTRIAL COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 9/03

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential.

Tri-Valley CUSD #3

Motor Vehicle Accident Form FORM F			
Date of Accident:	/ /	Time of Accident:	☐ A.M. ☐ P.M.
Accident Address:			
City, State, Zip:		County:	
Weather Conditions:			

Vehicle Information			
Vehicle Make:		Vehicle Model:	
Year:		Vehicle Identification Number (VIN):	
State of Registration:			

Vehicle Driver			
Name of Driver:		Driver's Job Title:	
Drivers License Number (DRL):			
Is Driver CDL Licensed:	☐ Yes ☐ No	Driver Injured:	☐ Yes ☐ No
First Aid Administered:	☐ Yes ☐ No	Drug Tested:	☐ Yes ☐ No
Blood borne Pathogen Used:	☐ Yes ☐ No	Citation Issued:	☐ Yes ☐ No

Vehicle Passenger(s)			
Passenger #1:		Injured:	☐ Yes ☐ No
Passenger #2:		Injured:	☐ Yes ☐ No
Passenger #3:		Injured:	☐ Yes ☐ No

Hospital Information (Employee)	
Hospital Name:	
Hospital Address:	
City, State, Zip Code:	
Hospital Phone #:	

Other Vehicle Driver			
Name of Driver:		Was the Driver Injured:	☐ Yes ☐ No
Driver's Address:			
City, State, Zip:			
Vehicle Make:		Vehicle Model:	
Year:		Vehicle Identification Number (VIN):	
State of Registration:			
Insurance Company:			
Agent Name:			
Insurance Company Phone#:			

Other Vehicle Passenger(s)			
Passenger #1:		Injured:	☐ Yes ☐ No
Passenger #2:		Injured:	☐ Yes ☐ No
Passenger #3:		Injured:	☐ Yes ☐ No

Hospital Information (Other Driver)	
Hospital Name:	
Hospital Address:	
City, State, Zip Code:	
Hospital Phone #:	

Hospital Information (Other Vehicle Passenger(s))	
Hospital Name:	
Hospital Address:	
City, State, Zip Code:	
Hospital Phone #:	

Law Enforcement Agency Investigation			
☐ State Police ☐ County Police ☐ City Police			
Name of Officer:			
Badge #:		Phone#:	
Photographs Taken:		☐ Yes ☐ No	
Photographer's Phone #:			

Witness(es)	
Name of Witness #1:	
Witness Phone #:	
Witness Address:	
City, State, Zip:	
Witness involved in accident:	☐ Yes ☐ No
Name of Witness #2:	
Witness Phone #:	
Witness Address:	
City, State, Zip:	
Witness involved in accident:	☐ Yes ☐ No

Description of Accident

Administrator's Signature:	
Date Form Completed	

Tri-Valley CUSD #3

Property Damage Report Form
FORM G

Loss Information			
Date of Accident:	/ /	**Time of Accident:**	☐ A.M. ☐ P.M.
Address of Loss Location:			
City, State, Zip:			
Of Whom Reported:	☐ Police Dept. ☐ Fire Depart. ☐ Other: _____		
Type of Loss:	☐ Fire ☐ Theft ☐ Lightning ☐ Hail ☐ Flood ☐ Other : _____		
Description of Loss:			
Description of Damage:			
Estimated Cost of Damage:	$		

Witness Information			
Witnesses Name:		**Phone #:**	
Witness Address: **City, State, Zip Code:**			

Follow-Up Action Recommended

Follow-Up Action Taken

Additional Space for Any Diagrams

Administrator's Signature:	
Date Form Completed	

Tri-Valley CUSD #3

Public Liability Report Form
FORM H

Date of Accident:	/ /	**Time of Accident:**	☐ A.M. ☐ P.M.
Name of Injured:		**Phone #:**	
Address:			
City, State, Zip:			
Age:		**Sex:**	☐ Male ☐ Female
Location of Incident:			
Owner of Property Damaged or Name of Injured Party:		**Estimate Amount:**	$
Describe Injury:			
How did the Incident Occur:			
Treatment for Injury:			

Emergency Personnel / Hospital Information	
Was a First Responder Involved:	☐ Yes ☐ No
Was an Ambulance Service Involved:	☐ Yes ☐ No
If So, Which Service:	
What Hospital was the Injured Taken To:	
Corrective Action	
Identify specific Management Controls (Policies/Procedures, Training, Enforcement, and Monitoring) to eliminate Incident:	

Witness(es)	
Name of Witness #1:	
Witness Phone #:	
Witness Address:	
City, State, Zip:	
Witness involved in accident:	☐ Yes ☐ No
Name of Witness #2:	
Witness Phone #:	
Witness Address:	
City, State, Zip:	
Witness involved in accident:	☐ Yes ☐ No

Administrator's Signature:	
Date Form Completed	

Tri-Valley CUSD #3

Unsafe Practices & Hazardous Conditions Report
FORM I

Condition is not safe and may cause injury.

- ☐ Personal danger of contact with electricity, high heat, or chemical
- ☐ Danger of being caught on, caught in, or caught between
- ☐ Danger of hazard inhalation, ingestion, or absorption
- ☐ Danger of being struck by or struck against
- ☐ Danger of slips, trips, or falls
- ☐ Other (Please Specify):_____

A hazard can be a violation of safety rules, standards, or regulations.

Employee Reporting Incident:			
Date of Accident:	/ /	**Time:**	☐ A.M. ☐ P.M.
Reported To:			
Please describe hazardous / dangerous condition and location:			
If possible, identify at least one reasonable solution to the hazard:			
What is the priority of required action to this hazard:	☐ High - Action required immediately or ASAP ☐ Medium - Action required within 24 hours ☐ Low - Action required as soon as time allows		

Employee Signature: _____ Date: _____

Administration Use Only			
Work Order #:		**Date of Repairs/ Hazard Control:**	/ /
Repaired By:			
Corrective Action:			

Tri-Valley CUSD #3

Student Accident Report Form FORM J			
Student's Name:			
Date of Accident:	/ /	**Time of Accident:**	☐ A.M. ☐ P.M.
Student's Date of Birth:	/ /	**Student's Grade:**	
Student's Sex:	☐ Male ☐ Female		

Accident Information	
Name of School where accident occurred:	
Place of accident (i.e. – playground, gym, cafeteria, etc.):	
Nature of the Injury:	
Detailed Description of the Accident, How did it occur:	
Was first aid given?	☐ Yes ☐ No
Did the student seek medical treatment?	☐ Yes ☐ No
If yes, Name and Address of the Doctor/Hospital:	
Was the student hospitalized?	☐ Yes ☐ No
Was the student absent from school due to the accident?	☐ Yes ☐ No
Who was the Teacher on duty at the time of the accident:	
Witnesses and Statements:	

Parent/Guardian Information	
Name of Parents or Guardian:	
Were the student's parents/guardian notified of the incident?	☐ Yes ☐ No
If yes, explain Parent Notification:	

Administrator's Signature:	
Date Form Completed	