FRANKLIN COUNTY FISCAL COURT
ACCIDENT REVIEW/INJURY REPORTS

EMPLOYEE ACCIDENTS

1. Department head or the next available supervisor needs to fill out a First Report of Injury to report all accidents and injuries and send to the Deputy County Judge Executive immediately. If the office is closed, notify the office on its next business day. The Deputy County Judge will forward all claims to the worker's compensation carrier and/or property and liability insurance carrier.
2. Employees are to be given a worker's compensation benefit card to take to the medical provider of choice. This card provides all pertinent information regarding a worker's compensation claim.
3. Department head or the next available supervisor needs to fill out an Injury Investigation Report and send to the Deputy County Judge Executive. This form will be reviewed by the Accident Review Committee. Findings will be reported to the department head.

VEHICLE ACCIDENT REPORTS

1. Department head or the next available supervisor needs to fill out an insurance Claim/Loss Form and send to the Deputy County Judge Executive immediately. If the office is closed, notify the office on its next business day. The Deputy County Judge will forward all claims to the property and liability insurance carrier.
2. Departments are to follow the Franklin County Fiscal Court Drug & Alcohol Policy to conduct alcohol and drug testing as needed.
3. Department head or the next available supervisor will need to obtain a police report (when necessary) and at least two vehicle repair estimates and turn in to the Deputy County Judge as soon as possible following the accident.
4. If medical attention to the employee is necessary, please follow the employee accident instructions above. If the worker's compensation benefit cards are not available, the employee or the department head should notify the medical provider that all billing will be sent to the worker's compensation insurance and provide them with the Deputy County Judge's contact information. The Deputy County Judge will follow up with the medical provider to ensure that proper billing is maintained so the employee and/or the health insurance carrier is not billed for services.
5. Department head or the next available supervisor needs to fill out an Accident/Injury Report and send to the Deputy County Judge Executive. This form will be reviewed by the Accident Review Committee. Findings will be reported to the department head.

LIABILITY INVESTIGATION REPORT

1. Department head or the next available supervisor needs to fill out a Liability Investigation Report and send to the Deputy County Judge Executive. This form is necessary when an employee damages property outside of county ownership and/or injures an outside party. This form will be reviewed by the Accident Review Committee. Findings will be reported to the department head.
2. Take photographs and include police reports where applicable.

FRANKLIN COUNTY ACCIDENT REVIEW COMMITTEE
ACCIDENT/INJURY REPORTS

SECTION A (to be completed by Driver/Operator)
Claim Number (to be assigned by Deputy County Judge or Insurance Carrier _____

Driver's Name_____ Report Date_____Department _____

Date of Incident_____ Time of Incident _____ Location of Incident_____

_____

Weather Conditions_____

Description of Incident _____

_____

_____

Primary Cause of Incident _____

Signature: _____ Date: _____

****

SECTION B (to be completed by Employee's Supervisor)
I have reviewed this investigation with the employee/driver involved and note the following:
_____

_____

Name _____ Signature_____ Date_____

****

SECTION C (to be completed by Accident Review Committee)

In consideration of the facts indicated, the following action should be taken to prevent such an incident/accident in the future: _____

_____

_____

Employee/Driver notified in writing _____ Date notified _____

Employee/Driver notified verbally _____ Date notified _____

Signature: _____ Date: _____

Signature: _____ Date: _____

FRANKLIN COUNTY FISCAL COURT
INJURY INVESTIGATION REPORT

This report is not a substitute for the First Report of Injury Form. This report is intended to help correct problems, not to criticize or penalize employees injured while working. The information provided below shall be used to identify and correct unsafe work practices or conditions.

Employee Name _____ Date of Injury _____

Department _____ _ Claim Number _____ Date Reported _____

****

Cause of Incident:

Work Practice:

_____ Disobeyed policy/safety rules
_____ Did not use a mechanical lift
_____ Poor body mechanics
_____ Unsafe behavior/horseplay
_____ Improper protective equipment
_____ Improper clothing/jewelry
_____ Unauthorized activity
_____ Other

Work Condition:

_____ Lack of training/instructions
_____ Wet spot/fluid leak
_____ Unsafe equipment
_____ Poor housekeeping
_____ Poor lighting
_____ Inoperative safety devices
_____ Poor ventilation
_____ Other

Incident Review: Detail what the employee was doing, how he/she was performing duties and what objects, tools, structures or equipment were involved: _____

Corrective Actions: Explain what actions were taken to correct the unsafe acts or conditions:

_____

Who is responsible to implement _____ Date for corrective action to be completed _____

Signature of Supervisor completing report _____ Date _____

Signature of Department Head _____ Date _____

Witness: Name _____ Position/Title _____

Statement _____

SECTION TO BE COMPLETED BY ACCIDENT REVIEW COMMITTEE:

In consideration of the facts indicated, the following action should be taken to prevent such an incident/accident in the future: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

FRANKLIN COUNTY FISCAL COURT
LIABILITY INVESTIGATION REPORT

Claim Number _____

Name of injured/owner of damaged property _____

Address _____Telephone _____

Location of Incident _____

Date and Time of Incident _____ Lighting _____ Weather _____

Nature of Injury/damage _____

Suspected cause of incident _____

Witnesses:

Name _____ Telephone _____

Name _____ Telephone _____

Statement of injured/owner of damaged property _____

_____

Statement of employee involved or witness' statement _____

_____

Actions to be taken to prevent further incidents of this type _____

_____

Signature of employee _____ Date _____

Signature of Supervisor _____ Date _____

*Immediately take photographs of the area where the incident occurred if possible.

SECTION TO BE COMPLETED BY ACCIDENT REVIEW COMMITTEE:

In consideration of the facts indicated, the following action should be taken to prevent such an incident/accident in the future: _____

Signature: _____ Date: _____

Signature: _____ Date: _____