



**CITY OF DUBLIN
ADMINISTRATIVE ORDERS
OF THE CITY MANAGER**

ADMINISTRATIVE ORDER 3.3
TO: All City Employees
FROM: Marsha I. Grigsby, City Manager
SUBJECT: Accident/Injury Reports/Exposure Records
DATE: February 11, 2014
Supersedes and Replaces Administrative Order 3.3 dated 03/03/02 Regarding Same Subject.

I. PURPOSE/SCOPE

The purpose of this Administrative Order is to establish procedures regarding the completion and maintenance of accident, injury, illness, and exposure records. This Administrative Order shall be applicable to all City of Dublin employees and all Department/Division Heads and supervisory personnel shall be responsible for ensuring compliance with the reporting and record keeping procedures contained herein.

II. REPORTING/RECORD KEEPING PROCEDURES/REQUIREMENTS

The following record keeping procedures/requirements are hereby established. These procedures/requirements shall be reviewed annually by the Risk Manager to ensure the City's procedures/requirements are in compliance with any revisions to the safety standards governed by Chapter 4167 of the Ohio Revised Code or of Chapter 1347 of the Ohio Revised Code.

A. Injury Investigation Reporting Procedure

- (1) Supervisors will be responsible for investigating work-related accidents and illnesses and reporting them to the Risk Manager using the attached Injury Investigation Report form (P-26).
- (2) When an employee encounters a work-related injury, the attached Injury Investigation Report (P-26) shall be completed and filed within the

Division to which the employee is assigned. A copy must be forwarded to the Risk Manager. This report should be submitted as soon as possible after an accident has been incurred, however, in no case should it be submitted later than three (3) calendar days following the date of injury.

- (3) Part 1 of the attached form (P-26) shall be completed by the employee; Part II shall be completed by the employee's immediate supervisor. If applicable, P-26S must be completed in its entirety by the employee. The completed report form (P-26) shall then be reviewed and signed by the appropriate Division Head who shall then forward said report to the appropriate Department Head (if applicable) for review and signature. The Department Head shall then forward the report to the Risk Manager/Division of Human Resources for further processing. (Where no formal Department Head exists, said report shall be forwarded directly from Division Head to the Risk Manager/Division of Human Resources. .
- (4) In the event professional medical treatment is sought for the injury/illness, the employee must obtain a Self-Insured Workers' Compensation identification card from their Supervisor and present it to the medical professional confirming that the injury is work-related. The employee must also complete a Bureau of Workers' Compensation Form FROI-1 (copy attached). Copies of these forms are usually available at the medical facility. If, however, said form is not available, one may be obtained from the Division of Human Resources or DubNet. .
- (5) All injuries should be reported to the employee's supervisor immediately, but in no case later than 3 calendar days following the date of injury. Failure to report an injury may preclude approval of a claim by the City of Dublin and/or the Bureau of Workers' Compensation, and may result in disciplinary action against the employee for failure to comply with the reporting procedures.
- (6) All lost time for full-time personnel due to a work-related injury must also be reported through the use of a City Leave Request Form and a BWC Medco-14 form or supporting documentation from a licensed physician justifying that the employee is unable to return to full work status due to the illness or injury.
- (7) Each Division Director shall assign one employee to assimilate accident, injury, training, and health assessment records and forward to the Risk Managers office. .
- (8) PC Compliance Safety Management Software – all data from injury and illness reporting form P-26 shall be entered into this database. This

software program shall be used to create the OSHA 300 log/PERRP 300AP log and the OSHA 300A/PERRP A log. In addition, managers shall utilize this database upon request from Risk Management, lost time reports and other informational graphs necessary for the review and management of injury related issues.

B. Log and Summary of Occupational Injuries and Illnesses (OSHA Form 300/PERRP 300AP)

The Risk Manager or other designated employee shall have the following responsibilities concerning the maintenance of the annual log and summary of recordable occupational injuries and illnesses:

- (1) Maintain a log and summary of all recordable occupational injuries and illnesses by calendar year.
- (2) Utilize PERRP 300P and enter information onto the log within six (6) working days after receipt of information that a recordable event has occurred.

C. Annual Summary

The Risk Manager, or other designated employee shall be responsible for completing and posting the attached annual summary of occupational injuries and illness by February 1 of each calendar year. This summary must remain posted until May 1. This summary will consist of the annual totals from the PERRP 300P and will include the following:

- (1) Calendar year covered;
- (2) Name and address of employer;
- (3) Certification signature, title, and date;

D. General Records Maintenance

The records mentioned above must be filed separately and maintained for each calendar year.

E. Records Retention Schedule

Records maintained under this section shall be retained for the following time periods following the end of the year to which they relate.

DOCUMENT	RETENTION PERIOD

DOCUMENT	RETENTION PERIOD
Log and summary of all recordable occupational injuries and illnesses (PERRP 300AP).	Retained for five (5) years.
Accident reports/supplementary records (P-26 form) for each illness or injury.	Retained for five (5) years.
Employee exposure records, as described in 29 CFR 1910.20 (Access to Records Policy).	Retained for 30 years.
Employee medical records.	Retained for the career of employee, plus thirty (30) years.
Employee exposure to blood borne pathogen records as described in 29 CFR 1910.1030.	Retained for the career of employee, plus thirty (30) years.
Noise exposure records.	Retained for twenty-five (25) years.
Audiometric test records as described in 29 CFR 1910.195.	Retained for duration of affected employee=s employment.

Records other than those listed above, e.g., health insurance records, etc., have no OSHA retention schedule; however, they remain subject to retention under Section 149.42 of the Ohio Revised Code.

F. Records Destruction

Although the above records may have reached a date on which they can be purged, Ohio Law, per chapter 149, dictates that appropriate authorization be received before any public record can be destroyed.

Attachments

**INJURY INVESTIGATION REPORT
PART I (EMPLOYEE)**

Case or File No. _____ (Risk Management) Date of Report: ____/____/____
Injured Employee: _____ Date of Injury _____
(First, Middle, Last)
Home Address: _____ Phone: _____
Social Security Number _____ Date of Birth: ____/____/____
Time of Injury: _____ AM/PM Time Employee Began Work _____ AM/PM Male Female
Position: _____ Date of Hire: ____/____/____ Full-Time Seasonal
Name of Supervisor: _____ Date You Initially Reported the Injury: ____/____/____

To Whom Was Injury Reported: _____ Vehicle Number: _____
Division: _____ Was Place of Accident or Exposure on Employer's Premises? Yes No
Place of Accident or
Exposure: _____
(No. and street, city or town, state and zip code)

What was the employee doing **just before** the incident occurred? (Be specific. Use of tools, equipment, procedure, etc.)

Description of injury or illness in detail and indicate the part of body affected: _____

Was Personal Protective Equipment Used? Yes No If no, explain: _____
Did you seek professional medical treatment for this injury? Yes No

If so, state name and address of physician and/or hospital: _____
Was employee treated in an emergency room? Yes No
Was employee hospitalized overnight as an in-patient? Yes No

Name of witnesses: _____
Is this an aggravation of a previous injury? Yes No Have you ever had a similar injury: Yes No
Did this injury involve lost time from work? Yes No If yes, estimate the number of days or hours: _____

The above statements have been made by me and are true and correct to the best of my knowledge. By signing this form I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat or examine me or who may have information of any kind which may be used to render a decision in my claim for injury/disease of _____, 20____ from disclosing such knowledge to my employer and/or the Third Party Administrator or Managed Care Organization (Representative of employer). A copy of this form will serve same as the original.

Employee Signature

Date

PART II (SUPERVISOR)

FORM MUST BE COMPLETE

State nature of work employee was performing at the time of injury: _____

Reasonable suspicion of drug/alcohol use? Yes No Recommend drug/alcohol testing? Yes No
Were safety devices being used? Yes No Was machinery, equipment, etc. in good working condition? Yes No

If no, explain why not: _____

How did injury happen? (Be specific): _____

Is this a lost time injury? Yes No Did employee die? Yes No If yes, date of death ____/____/____

Had the employee been instructed in the work being performed? Yes No If so, by whom? _____

Was injury due to unsafe act on the part of the employee? Yes No If so, explain (Be Specific): _____

Name of the **object or substance** which directly injured the employee: _____

Names of any witnesses: _____

What action has been taken to prevent a recurrence of this type of injury? _____

Did result of injury require or involve? (Check if applicable):

_____ Loss of Consciousness

_____ Medical Treatment

_____ Restriction of Work or Motion

_____ Transfer to Another Job

(If any of above circumstances are checked, this is a recordable accident.)

First Line Supervisor Date

Administrative Supervisor Date

Director Date

Risk Manager Date

**CITY OF DUBLIN
EMPLOYEE'S BACK INJURY REPORT**

THIS FORM IS TO BE COMPLETED AND SIGNED BY EMPLOYEE WHEN BACK INJURY IS REPORTED.

Employee Name: _____

1. What part of your back hurts now? _____

2. When did you first notice the back pain? _____

3. What were you doing at the time of injury (explain in detail)? _____

4. If you were lifting an object, what was it and how heavy? _____

5. What was your exact position when pain was first noticed? _____

6. What did you feel? _____

7. What was the length between the injury and your disability? _____

8. Did anyone see you get hurt? (Circle) Yes No If so, give name: _____

9. Did you report or mention this injury to anyone? (Circle) Yes No

If so, who and when? _____

10. Did you ever hurt your back before? (Circle) Yes No

If so, when? _____ What part of your back? _____

Were you treated by a doctor? (Circle) Yes No If so, date: _____

Has it given further trouble? (Circle) Yes No If yes, explain: _____

11. Have you ever received or filed for compensation because of a back injury? (Circle) Yes No

Other injury? (Circle) Yes No

If so, list Bureau of Workers' Compensation claim number(s) _____

MEDICAL RELEASE

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, the Third Party Administrator or the Managed Care Organization and employer designated representative. A copy of this form will serve as the original.

Employee Name (Print) _____

Employee Signature _____ Date (required) _____