



Warren County Incident Management Guidelines

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Warren County Incident Management Guidelines

For use with: employee, non-employee, volunteer, visitor injuries; property damage claims and; near miss incidents.

I. POLICY

It is Warren County's policy that all unsafe incidents, injuries, near misses and property damage occurrences are reported to Department Heads for the purpose of evaluating data to prevent further occurrence. All incidents shall be recorded on the appropriate accident reporting forms contained herein.

The Employee Safety and Health Committee and the Risk Management Steering Committee shall be responsible for evaluating incident trends and making recommendations to the County for corrective actions.

II. IMPLEMENTATION

In order to optimize management of injuries and loss in the County's operating facilities and those affecting County employees, these guidelines describe a set of forms and establish timelines designed to assist departments in documenting incidents, injuries, near misses and property damage occurrences. Any questions about these guidelines should be addressed to the Insurance Administrator.

It is the policy of Warren County that management investigate the following:

- All accidents resulting in injury.
- Significant loss or damage to property.
- Any incident that did not result in injury, damage or loss, but could have under similar circumstances (near misses).

III. DOCUMENTATION

A. Written Procedures for Reporting Incidents

1. Procedures for Reporting of Employee Occupational Injury/Illnesses

All injuries and illnesses, regardless of severity, will be reported to the area Supervisor in accordance with the *Injury/Loss Management Reporting Schedule (Appendix A)*. The following forms should be used to report an employee injury or illness:

Employee's Report of Incident

For occupational injury and/or illness, the employee should complete the packet of forms "Procedure for reporting workers' compensation injury" (*Appendix B*) as soon as they have received appropriate treatment and are capable of returning to the site. The completed report should be provided immediately to his/her Supervisor. In certain instances, the employee may be unable to complete the Employee's Report due to hospitalization or transportation directly home from the health care facility. In such cases, reasonable effort should be made to have the Employee's Report completed as soon as the employee is capable of doing so, even though he/she may not be cleared to work. The Supervisor and Department Head should follow the instructions on the forms packet to complete their portion of the forms required.

Accident Investigation Witness Statement

A separate *Witness Statement* (included in the appropriate Appendix forms) must be completed by each employee that witnessed an accident, and when possible, by each

non-employee witness. The fully completed form should be returned immediately to the Supervisor who, in turn, will provide them to the Department Head.

Supervisor's Report of Accident Investigation

A ***Supervisor's Report of Accident Investigation*** (included in the appropriate Appendix forms), must be completed for every incident that requires an Employee's Report. The report must be fully completed and should represent a thorough investigation of the incident, including the root cause. The statement of actions taken to prevent similar accidents or illnesses, and recommendations for additional action, should be well thought out. In many situations, sketches or photographs of the area involved are useful in conveying information regarding the location and circumstances related to an accident. Where possible, sites should retain a digital or disposal camera for this purpose. The photographs should be taken as soon after the accident as possible and the date and time of each photograph recorded. Additional sheets should be attached if the spaces provided on the form are inadequate or the situation warrants supplemental clarification. The originals of all reports should be forwarded to the Department Head.

In those instances where it is infeasible to complete the report within the specified time frame, the supervisor can forward supplemental information as soon as the information becomes available. However, this exception only applies to information that is not possible to obtain at the time of the incident, e.g. if the employee is not capable of completing the Employee's Report or being interviewed. This document is to be attached to the Employee's Report and forwarded to the Department Head as soon as possible.

Incident Tracking Log

Incidents that are not severe, where the employee did not seek medical treatment and did not miss time from work, can be recorded on the Incident Tracking Log (***Appendix G***). In some cases it is advisable to perform an investigation of the accident using the near miss forms/process (***Appendix D***). However, the Incident Tracking Log can be used in place of the "Procedure for reporting workers' compensation injury" (***Appendix B***) when the employee didn't seek treatment or miss time from work. If the employee's injury becomes severe enough to seek medical treatment or the employee misses time from work then the forms "Procedure for reporting workers' compensation injury" (***Appendix B***) must be completed and a copy of the appropriate page from the Incident Tracking Log should be forwarded to Self-Insurance with the injury report forms. A copy of the Incident Tracking Log will be collected at least semi-annually by Self-Insurance and reviewed for injury trending purposes.

2. Procedures for Reporting of Non-Employee, Volunteer and Visitor Injuries and Illnesses

To the extent possible, the timeframes for reporting and documenting non-employee, volunteers and visitor incidents are the same as for employees. It is especially important that photographs be taken for all non-employee accidents. A separate *Witness Statement* (included in the appropriate Appendix forms) must be completed by each employee that witnessed an accident, and when possible, by each non-employee witness. The fully completed form should be returned immediately to the supervisor who, in turn, will provide them to the Department Head. ***Appendix C*** contains the forms for reporting non-employee, volunteer and visitor injuries.

3. Procedures for the Reporting of Employee Near Misses

The County's objective is to encourage its employees to report all near misses so that

deficiencies in equipment, procedures and training can be identified and corrected.

Forms for near miss incidents are to be completed when an incident occurs that did not result in an injury or significant loss but may have under similar circumstances. The forms required to report near miss incidents are located in **Appendix D**. If there are multiple employees involved, each employee should complete his/her own report. Witnesses should complete the appropriate *Witness Statement*. All reports should be submitted to the Supervisor who will complete the Supervisor's Report of Accident Investigation. The report must be fully completed and should represent a thorough investigation of the near miss including the root cause. The statement of actions taken to prevent similar incidents, and recommendations for additional action should be well thought out. In many situations, sketches or photographs of the area involved are useful in conveying information regarding the location and circumstances related to a near miss. Where possible, sites should retain a digital camera or disposal camera for this purpose. The photographs should be taken as soon after the incident as possible and the date and time of each photograph recorded. Additional sheets should be attached if the spaces provided on the form are inadequate or the situation warrants supplemental clarification. Originals of all reports should be forwarded to the Department Head within 3 business days.

4. **Procedures for Reporting of Non-Employee Near Misses**

To the extent possible, the timeframes for reporting and documenting non-employee, visitors, and volunteers near misses are the same as for employees.

5. **Procedures for Reporting of Property Damage**

The County Property Damage Report (**Appendix E**) must be completed any time an incident results in loss for the County. This loss could be to County facilities and be caused by County employees, non-employees, volunteers or visitors, or it could be to the property of others such as to others vehicles, property or equipment, both on and off the County's property. Losses to the property of others would have to be caused by a County employee and/or equipment. Photographs of the actual damage and the area involved should be taken as soon after the incident as possible and the date and time of each photograph recorded. The photographs and supporting information should be included with the Damage Report. Witnesses should complete the appropriate *Witness Statement*. All reports should be submitted to the Supervisor who will complete the Supervisor's Report of Accident Investigation. A copy of the reports should be forwarded to the Department Head within 3 working days. The portions of the forms that cannot be completed within 3 days (e.g. total costs of repair) are to be completed when final invoices are received.

6. **Procedures for Reporting County Automobile Damage**

The County Automobile Loss Report (**Appendix F**) must be completed any time an incident results in damage to a County Automobile. Photographs of the actual damage and the area involved should be taken as soon after the incident as possible and the date and time of each photograph recorded. The photographs and supporting information should be included with the Automobile Loss Report. Witnesses should complete the appropriate *Witness Statement*. All reports should be submitted to the Supervisor who will complete the Supervisor's Report of Accident Investigation. A copy of the reports should be forwarded to the Department Head within 3 working days. The portions of the forms that cannot be completed within 3 days (e.g. total costs of repair) are to be completed when final invoices are received. The complete original is to be forwarded to the Department Head.

Appendix A

Attach Injury/Loss Management Reporting Schedule Here

INJURY/LOSS MANAGEMENT REPORTING SCHEDULE

<u>Event</u>	<u>Form(s) Required</u>	<u>Action</u>
Property damage to County property OR Damage to non-County property by County employee	County Property Damage Report Witness Report(s) <i>Appendix E</i>	Immediate verbal notification to Supervisor Forward documentation to the Department Head within 3 business days
Near Miss Incident	Near Miss Incident Report Supervisor's Report of Investigation Witness Report(s) <i>Appendix D</i>	Same-day verbal notification to Supervisor Forward documentation to the Department Head within 3 business days
Employee illness or injury: Minor injury – No medical care or lost time Minor Injury – medical care or lost time Serious Injury (inpatient hospital) Catastrophes (fatality or 3 or more inpatient hospitalizations)	 Entry on Incident Tracking Log <i>Appendix G</i> Near Miss Incident Report forms <i>Appendix D</i> (as needed) Procedure for reporting workers' compensation injury forms <i>Appendix B</i> Procedure for reporting workers' compensation injury forms <i>Appendix B</i> Procedure for reporting workers' compensation injury forms <i>Appendix B</i>	Immediate verbal notification to Supervisor (in all cases) Call Department Head within 1 business day. Send forms to Department Head within 3 business days. Call Department Head within 1 business day. Send forms to Department Head within 3 business days. Call Department Head within 8 hrs. Send forms to Department Head within 3 business days. Call the Department Head, County Administrator, County Attorney and Insurance Administrator immediately (24/7). Call to NYS DOL PESH 518-457-5508 within 8 hours.
Non-employee Accidents	Non-Employee, Volunteer, Visitor injury report forms <i>Appendix C</i>	Same verbal reporting requirements as employees.
Auto Accidents	County Automobile Loss report forms <i>Appendix F</i>	Call Supervisor immediately. Super to call Sheriff's Office. Send forms to Department Head within 3 business day Drug testing as appropriate

Note: All forms can be found at www.warrencountyny.gov/insurance

Appendix B

Attach Employee Injury Report forms here

- Procedure for reporting Workers' Compensation Injuries
- Employee Claim forms including C3
- Various handouts for the injured employee
- Employers first report of injury C2F
- Accident Investigation Witness Statements
- Supervisors Report of Accident Investigation

Procedure for Reporting Workers' Compensation Injury

For Warren County Departments ONLY

Employee Responsibilities:

1. Complete "Employee Claim" (Form C-3.0) – 2 pages
2. Complete "Supplement to C3 form" – 1 page
3. Complete "Limited Release of Health Information" (Form C-3.3) – 1 page
4. Complete "Authorization to Obtain Information" (WC Form 5) – 1 page

❖ The 4 forms above should be provided to your supervisor immediately.

If your injury requires medical care:

This packet contains forms that you will need to take with you to the treating provider & pharmacy.

Take a copy of "Workers' Compensation Encounter Form" (WC Form 10) with you to each doctor visit.

Tell your doctor or hospital to send all bills to the following address. Be sure to mark the date of injury clearly on all correspondence.

Warren County Self-Insurance, 1340 State Route 9, Lake George NY 12845

If you require pharmaceuticals for this injury, take the "Pharmacy Benefits" page with you to the pharmacy.

Provide your supervisor with proper medical documentation if time away from work is recommended.

If your injury requires medical treatment, you will receive a packet with claim information in the mail.

Supervisor Responsibilities:

- If the injury is serious or the employee is expected to be out of work more than a day, call Self-Insurance immediately to alert them to the claim. Then follow up with the paper work as soon as possible.
- Confirm that the employee has completed and given you the forms:
 - "Employee Claim" (Form C-3.0) – 2 pages
 - "Supplement to C3 form" – 1 page
 - "Limited Release of Health Information" (Form C-3.3) – 1 page
 - "Authorization to Obtain Information" (WC Form 5) – 1 page
- Advise and confirm that the employee has retained forms:

“Claimant Information Packet” – 2 pages

“Workers’ Compensation Encounter Form” – 1 page

“Pharmacy Network and Step Therapy Drug List” – 2 pages

- Complete the Employer Instructions section on the “Pharmacy Benefits” page and return that page to the employee.
- Complete Form C-2F – 3 pages
- If there were witness(es) to the accident, provide each witness with the form “Accident Investigation Witness Statement ”
- Complete Form “Supervisor’s Report of Accident Investigation, Supplement to C2 form”
- Forward completed Employee forms (4), completed Supervisors forms (2) and any Witness Statements to Self-Insurance.
- Notify Self-Insurance when employee returns to work OR if the employee’s condition changes.



Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ 2. Date of Birth: ____/____/____
First MI Last

3. Mailing address: _____
Number and Street/P.O. Box City State Zip Code

4. Social Security Number: _____ 5. Phone Number: (____) _____ 6. Gender: Male Female

7. Will you need a translator if you have to attend a Board hearing? Yes No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____

3. Your work address: _____
Number and Street City State Zip Code

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Yes No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) Full Time Part Time Seasonal Volunteer Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? Yes No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ AM PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? Yes No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____
First MI Last

DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? Yes No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? Yes No
If yes, your vehicle employer's vehicle other vehicle License plate number (if known): _____

If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? Yes No
If yes, notice was given to: _____ orally in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? Yes No Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? Yes, on what date? ____/____/____ No, skip to Section F.

2. Have you returned to work? Yes No If yes, on what date? ____/____/____ regular duty limited duty

3. If you have returned to work, who are you working for now? Same employer New employer Self employed

4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ None received (skip to question F-5)

2. Were you treated on site? Yes No

3. Where did you receive your first off site medical treatment for your injury/illness? none received Emergency Room
 Doctor's office Clinic/Hospital/Urgent Care Hospital Stay over 24 hours

Name and address where you were first treated: _____
_____ Phone Number: (____) _____

4. Are you still being treated for this injury/illness? Yes No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (____) _____

5. Do you remember having another injury to the same body part or a similar illness? Yes No
If yes, were you treated by a doctor? Yes No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

6. Was the previous injury/illness work related? Yes No
If yes, were you working for the same employer that you work for now? Yes No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____
An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

Employee's Report of Incident Supplement to C3 Form

(To be completed immediately. This form does not replace Worker's Compensation forms. Established procedures for Worker's Compensation reporting must continue to be followed.)

Personal Information

Name	
Time in current position	

Accident Information

Date of Accident		Time of day that you began work on day of accident	
Weather Conditions at Time of Accident			

How Could the Accident Have Been Prevented?

Protective Equipment in Use at the time of the Accident:

Signed:

Employee Name		Date	
Supervisor		Date	
Department Head		Date	



Limited Release of Health Information (HIPAA)

C -3.3

State of New York - Workers' Compensation Board

WCB Case No. (if you know it): _____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your *previous* injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A copy of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name: _____ 2. Social Security Number: _____ - _____ - _____
3. Mailing Address: _____
4. Date of Birth: ____/____/____ 5. Date of the current injury/illness: ____/____/____
6. Current injury/illness, including all body parts injured: _____
7. Your legal representative's name and address (if any): _____

Check here if you allow your health care provider(s) to release **mental health care** information.

B. YOUR HEALTH CARE PROVIDER(S) (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider: _____ 2. Phone Number: (____) _____
3. Mailing Address: _____
4. Other provider (if any): _____ 5. Phone Number: (____) _____
6. Mailing Address: _____

C. READ AND SIGN BELOW. I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) Date

AUTHORIZATION TO OBTAIN INFORMATION

**AUTHORIZATION FOR THE USE AND DISCLOSURE
OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize Warren County Self-Insurance to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Person(s) / organizations authorized to use or disclose the information:

Any medical facility that has treated me in the past.

2. Person(s) / organization to whom the requested use or disclosure may be made:

Warren County Self-Insurance and/or its agents.

3. Specific description of information that may be used or disclosed:

Copies of medical records including, but not limited to, patient questionnaires, patient intake sheets, referral forms, patient history forms, office notes, reports, charts, x-ray or other films, etc., and/or copies of hospital and medical records relating to services rendered to me for the following medical condition(s):

Any condition except those excluded below.

Excluding (1) any and all confidential HIV and AIDS related information protected under Article 27-F of the New York Public Health Law and (2) any and all confidential mental health records protected under Section 33.13 of the New York Mental Hygiene Law.

4. Purpose of the requested use or disclosure:

For the use in a pending Workers' Compensation claim brought by me.

5. I understand that I may revoke this authorization at any time by giving written notice to the person / organization that is providing the information I no longer want to be used or disclosed, except to the extent that action has already been taken in reliance on this authorization.

6. I understand that the medical provider may not condition the provision of health care services on whether I sign this authorization.

7. This authorization expires upon the final closure of the Workers' Compensation claim brought by the individual.

8. Photocopies of this authorization should be accepted as original.

Signature of Individual Authorizing Use/Disclosure

Date

Printed Name of Individual

For Office Use: Date of Injury: _____ Carrier Case # _____ WCB# _____



Claimant Information Packet

WARREN COUNTY SELF-INSURANCE DEPARTMENT

1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249
Email: warrencountyinsurance@warrencountyny.gov

You were injured at work. What now?

If you've suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek the medical care that is necessary.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Report injuries as soon as possible but always within 30 days of the injury.
- Medical reports are necessary for your case. Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the NYS Workers' Compensation Board and with Warren County Self-Insurance, your employer's insurance carrier. Ask that your doctor complete the "Workers' Compensation Encounter Form" and fax it back to Warren County Self-Insurance. This may help expedite your claim. If your case is disputed, the Workers' Compensation Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, they must notify the Warren County Self-Insurance Department by filing a C-2 form. You should file an employee claim (C-3 form) reporting your injury as soon as possible. If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3. You should complete the "Authorization to Obtain Information" and give it to your employer immediately.

If you haven't already filed a C-3 or C-3.3 (if necessary), there are three ways to do it.

- Complete the paper forms that your employer provided to you and give them to the employer. Additionally, you can also mail this form to the Workers' Compensation Board.
- Visit www.wcb.ny.gov to complete the form
- Call 1-866-396-8314. A Workers' Compensation Board employee will complete the form with you.

Health Care Benefits

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Workers' Compensation Board disallows your case. If your case is disputed, the providers are paid when the Workers' Compensation Board decides your case. If the Workers' Compensation Board decides against you, or if you don't pursue a case, you will have to pay the doctor or hospital.

Warren County Self-Insurance covers medically necessary drugs and equipment that your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

Generally, you can choose any doctor authorized by the Workers' Compensation Board. You can also use occupational health clinics. Warren County participates in the ONECALL MEDICAL diagnostic radiology network, therefore if you require diagnostic radiology services (MRI, EMG, NCS, CT, Ultrasound, Bone Scan or Arthrograms) you or your physician must contact us before performing these tests. Additionally, Warren County participates in the TechHealth pharmacy benefits network. Therefore, pharmacy benefits must be obtained from a TechHealth network pharmacy.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and carriers dispute a claim. When that occurs, the Workers' Compensation Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Workers' Compensation Board sets their fees and they will be deducted from your lost wages award. You should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may be eligible to receive short term disability benefits while the case is heard. Check with your employer about disability benefits and ask for a DB-450 claim form. If your case is accepted, you will pay back the disability benefits out of your lost wages award.

Help is Available

People sometimes need help getting back to work. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for assistance. More information is also available on the NYS Workers' Compensation Board website at: <http://www.wcb.ny.gov>

What's Next?

Warren County Self-Insurance will send you information and documentation if your claim is accepted or denied. When the claim is accepted, your treatment will be paid and lost wages benefits begin. If your case is challenged, the Workers' Compensation Board will notify you about resolving the case. If more information is necessary, the Workers' Compensation Board will contact you and tell you how to file it.

Important Contact Information

Workers' Compensation Board	877-632-4996
Warren County Self-Insurance	518-761-6528

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC# _____

Workers' Compensation Encounter Form

*To the Employee: Give one copy of this form to your physician/ chiropractor at each visit.
(Call Self-Insurance for additional forms or duplicate this one.)*

Patient Name: _____

Date of Service: _____ Date of Birth: _____

In your opinion, is the disability arising out of and in the course of employment or occupational disease? Yes No

Date of injury: _____

Is the patient losing time from work? Yes / No First day of lost time: ___ / ___ / ___

Can the patient return to work? Full duty / Modified duty ___ / ___ / ___

Modified duty requirements: _____

Diagnosis: _____

Prescriptions given to treat injury: _____

Treatment Plan: _____

Percentage of impairment (0-100%): _____ % Temporary / Permanent

Apportionment? Yes No Pre-existing _____ % Current injury _____ %

Next visit: ___ / ___ / ___ Time: _____ with Provider: _____

Providers Signature: _____ Date: ___ / ___ / ___

Please Fax this form immediately to: 518-761-6249



Pharmacy Network

The TechHealth pharmacy network includes many national chain pharmacies as listed below. Many independent pharmacies are also included in the network. If you need assistance in locating a participating pharmacy, visit www.techhealth.com or contact a TechHealth representative at 1.866.207.1472 for assistance.

A

A&P
Accredo Health
Acme Pharmacy
Ahold, Inc.
Alegent Retail Pharmacies
Astrup Drug Inc
Aurora Pharmacy, Inc.

B

Bartell Drug Company
Beuhlers Food Markets
Bi Mart
Big Y Foods Inc
Bi-Lo
Bi-Mart Corporation
Brookshire Brothers Food & Pharmacy
Brookshire's

C

Carle RX Express
Costco
CVS Corporation

D

Dahl's Food
Dierbergs Markets, Inc.
Discount Drug Mart
Document's Discount
Drugs, Ltd.
Dominicks
Drug World Pharmacies
Duane Reade

F

Fitzgerald and Huling
Pharmacy
Food City
Food Lion
Fred's Stores of
Tennessee, Inc. Fruth
Pharmacy, Inc.

G

Giant Eagle, Inc.
Good Day Pharmacy
Gristedes Sloans

H

H & H Drug Stores
H.E. Butt Grocery Company
Haggen Food & Pharmacy
Hannaford
Harp's Food Stores, Inc.
Harris Teeter, Inc.
Hartig USA Drug Stores
Heartland Pharmacy Inc.
Hi-School Pharmacy, Inc.
Homeland Stores, Inc.
Horton and Converse
Pharmacies
Hy-Vee, Inc.

I

Ingles Markets, Inc.

J

Jordan Drug

K

K Mart Corporation
Kash N Karry
Kaiser
Kelsey-Seybold
Pharmacy Division
Kerr Drug
King Kullen Grocery
Company, Inc. King
Soopers
Kinney Drugs, Inc.
Klingensmith's Drug Stores
Kohls Pharmacy and
Home Care
Kroger Co.
K-VA-T Food Stores Inc

L

Long Drug Stores
Louis and Clark

M

Market Basket Pharmacies
Marsh Drugs, LLC
Marshfield Clinic Pharmacy
Martins Super Markets
Maxor
Mays
Med-Fast Pharmacy

Medfusion Rx LLC
Medicine Centers of Atlanta
Medicine Chest Pharmacies
Medicine Shoppe
Meijer Pharmacy
Minyard Pharmacy
MK Stores
Moore & King

N

Navarro Discount
Pharmacies

O

Option Care Enterprises Inc

P

Pamida Pharmacy
Pathmark Stores
Payless Drug LTC Pharmacy
Peoples Pharmacy
Pharmacard Pharmacy
Pharmacy Business
Associates
Pharmacy Express
Pharmacy Plus
Piggly Wiggly
Price Chopper
Pill Box Inc.
Price Cutter
Prof Specialized Pharmacies
Publix Super Markets, Inc.

Q

QOL Meds
Quick Check Food Stores
Quinn Supers, Inc.

R

Raley's Family of
Fine Stores
Ralph's Pharmacy
Receipt Pharmacy
Randalls Pharmacies
Redners Markets
Riesbecks Pharmacy
Rite Aid Pharmacies
Ritzman Pharmcies, Inc.
Roundys Pharmacies

Rx Care Plus Pharmacies
Rx Discount Pharmacy Inc
Rx Plus Pharmacies

S

Safeway Pharmacies
Sam's Club
Save Mart Supermarkets
Sav-Mor Drug Stores
Shaws Pharmacy
Schnuck Markets, Inc.
Seip Drug Stores
Shopko Stores, Inc.
ShopRite
Snyder Drug Stores
Southern Family Markets
Stoner Drug Co
Stop N' Shop
SuperValu
Super D Drugs

T

Target Corporation
The Fred Albrecht
Grocery Company
Tom Thumb
Thrifty Dug Stores, Inc.
Tops Markets

U

U Save Pharmacy
United Supermarkets, Inc.
US Bioservices, Inc.
USA Super Drug

V

Von's
Value Drugs, Inc.

W

Walgreens
Wal-Mart Stores, Inc.
Wegman
Winn-Dixie Stores, Inc.

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Step Therapy Drug List

The step therapy program encourages safe and cost-effective medication use. Under this program, a “step” approach is required to receive coverage for certain medications. This means that before you use one of the brand-name drugs listed on the attached Step Therapy List, you will first need to try a similar, alternative medication. In most cases, this will be a generic drug. Generics are approved by the FDA as safe and effective. It is important that you share this list with your doctor to help coordinate your medication need.

KEY: Generics are listed in lower case; Brands in capitals.

Indication	Step Therapy Program	First Line (Step-One) Products	Second-Line (Step Two) Products
Analgesic	COX-2 Inhibitors	two different non-steroidal anti-inflammatory drugs (NSAID's)	Celebrex
	NSAID	1 NSAID	Arthrotec
	Migraine Medications	sumatriptan tablets	Brand triptans
Antispasmodic	Muscle relaxants	generic muscle relaxant	Amrix
Depression	SSRI/SNRI	bupropion, fluoxetine, fluvoxamine, paroxetine, citalopram, sertraline, venlafaxine IR	Effexor, Effexor XR, Cymbalta, Pristiq, Wellbutrin XL, venlafaxine XR
			Paxil, Paxil CR, Pexeva, Zoloft, Celexa, Lexapro, Luvox, Prozac, Prozac weekly, Sarafem
Gastrointestinal	PPI	omeprazole lansoprazole	Nexium, pantoprazole, Aciphex, Kapidex, Prevacid, Prilosec (brand) Zegerid, Protonix
Nerve Pain	Lyrica	gabapentin	Lyrica
Ophthalmic	Ophthalmic anti-inflammatory	diclofenac ophSoln	Acuvail™
Sleep	Sedative Hypnotics	zolpidem, zolpidem CR, zaleplon	Ambien, Ambien CR, Edluar, Lunesta, Rozerem, Sonata

Notes:

For the drug classification listed in the table above, members must have tried one First-Line medication within the past 120 days before moving to a Second-Line medication.

Within all Step Therapy programs, all brand drugs that have a generic equivalent are non-formulary



Pharmacy Benefits

Employee: Present letter to the PHARMACY

Welcome to TechHealth. Your employer, **Warren County** has selected TechHealth to be the preferred pharmacy benefit program provider to meet all your approved work related injury prescription needs and help you avoid unnecessary out of pocket expenses. TechHealth has over 65,500 pharmacies nationwide.

This letter **MUST BE PRESENTED** to your pharmacist when you drop off your workers' compensation prescription(s). You **may** be dispensed only a portion of the full prescription prescribed by the physician depending on the status of your claim at the time it is filled by the pharmacy. This should not be cause for alarm as it is not unusual for your claim to take 1-3 days to process. Once the claim has been accepted the remainder of the prescription will be available. A permanent prescription card specific to your injury will be mailed directly to you within the next 5 to 7 business days. Please note that this is valid only for medications prescribed to treat your compensable work related injury. You or your group health insurers are financially responsible for any other prescriptions.

If you have questions or need assistance in locating a participating pharmacy, please contact TechHealth at **1.866.207.1472**

Employer Instructions

****Attention Supervisor/Company Representative: Employee's Social Security and Date of Injury must be completed.****

Employee Name: _____ SSN#: _____ - _____ - _____

Date of Injury: ____/____/____ Company Contact Ph # _____

Representative Signature: _____ Date: ____/____/____

Pharmacy Instructions

The Injured Worker's employer participates in the TechHealth Pharmacy Benefit Program administered by *Informed RX*. A TechHealth Customer Service Representative is available, 24 hours a day, 7 days a week at **1.866.207.1472** to provide assistance claims processing. Please use the following information to submit the claim

RxBIN: 610011 PCN: IRX RXGrp: 91057FF Issuer: (80840)

MEMBER ID: SSN + Date of Injury (SSNMMDDYYYY-no dashes)

NAME: FIRST AND LAST NAME

**** Please note that TechHealth claims are submitted electronically and electronic approval of the claim will be returned, also with electronic submission there is no additional paperwork required by the pharmacy and payment is guaranteed for all electronically accepted claims****



State of New York - Workers' Compensation Board
Employer's First Report of
Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ Date of Injury _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Warren County Self-Insurance Plan Insurer ID W874754

Name Warren County Self-Insurance Plan

Info/Attn _____

Address 1340 State Route 9

City Lake George State NY

Postal Code 12845 Country USA

Claim Admin ID W874754

EMPLOYEE INFORMATION

First Name _____ Middle Name/Initial _____

Last Name _____ Suffix _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Phone Number _____ Date of Hire _____

Date of Birth _____ Gender Male Female Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ Date Employer Had Knowledge of the Injury _____

Employment Status _____ Date Employer Had Knowledge of Date of Disability _____

Estimated Weekly Wage _____ Number of Days Worked Per Week _____

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes No Employer Paid Salary in Lieu of Compensation Yes No

Initial Treatment No Medical Treatment Minor On-Site Treatment By Employer Minor Clinic/Hospital Treatment
 Emergency Evaluation Hospitalization Greater Than 24 Hours Future Major Medical/Lost Time Anticipated

Death Result of Injury Yes No Unknown Date of Death _____ Number of Dependents _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ Return To Work Type Actual Released

Initial Date Disability Began _____ Physical Restrictions Yes No

Initial Return to Work Date _____ Return To Work Same Employer Yes No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) Employer Lessee Other

Organization Name _____

Street _____ State _____

City _____ Postal Code _____

County _____ Country _____

Location Narrative _____

Witnesses

Business Phone Number

EMPLOYER INFORMATION

Name _____ Employer FEIN _____
UI Number _____ Manual Classification Code _____
Industry Code _____
Info/Attn _____
Mailing Address _____
City _____ State _____
Postal Code _____ Country _____
Physical Addr _____
City _____ State _____
Postal Code _____ Country _____
Contact Name _____
Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ Insured FEIN _____
Insured Type Insured Self-Insured Uninsured Insured Location ID _____
Policy Number ID n/a _____
Policy Effective Date _____ Policy Expiration Date _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who **KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION** as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit **SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.**

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form _____ Date _____
Print Name _____
Title _____ Phone Number _____

Accident Investigation Witness Statement

Personal Information

Name of Witness			
Address			
City, State, Zip			
Phone			

Employment Information

Department		Work Site	
Occupation		Supervisor	
Date of Hire		Time in current position	

Accident Information - Injured Person's Name: _____

Date accident occurred		Time of Accident	
Location of accident		Weather Conditions at time of Accident	

In your words, give a brief description of the accident:

How did the Injury Occur?

How Could the Accident Have Been Prevented?

Signed:

Witness Name		Date	
--------------	--	------	--

Supervisor's Report of Accident Investigation Supplement to C2 Form

(To be completed immediately. This form does not replace Worker's Compensation forms. Established procedures for Worker's Compensation reporting must continue to be followed.)

Date of Investigation:	Investigator:
Injured Person:	

Describe the accident in detail (include physical surroundings, equipment in use)

SPECIFY THE UNSAFE ACTS AND CONDITIONS WHICH LED TO THE ACCIDENT (Please circle all that apply):

Unsafe Acts:

<ul style="list-style-type: none">• Improper lifting, carrying, handling• Improper use of tools or equipment• Operating without authority• Failure to wear personal protective equipment• Failure to use safety devices• Failure to use proper tools/equipment• Failure to obey rules/procedures• Failure to secure ladders• Lack of adequate training	<ul style="list-style-type: none">• Transitioning to/from ladder• Misstep on ladder• Over-reaching on ladder• Using defective equipment• Overriding safety devices• Horseplay• Taking shortcuts or hurrying• Action of others• Other: _____
--	---

Unsafe Conditions:

<ul style="list-style-type: none">• Wet and/or slippery working surface• Defective floor and/or walking area• Congested work area• Poor housekeeping• Inadequate lighting• Inadequate guards• Inadequate design or maintenance	<ul style="list-style-type: none">• Lack of available personal protective equip• Lack of proper tools or equipment• Defective tools or equipment• Inadequate warning system• Projection hazards• Hazardous atmosphere• Other: _____
--	---

Supervisor's Report of Accident Investigation Supplement to C2 Form – Page 2

Personal Factors:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Improper work habits • Unaware of work hazard • Improper motivation | <ul style="list-style-type: none"> • Improper attire • Improper attitude • Unwilling to follow work rules • Other: _____ |
|---|--|

Was there an infraction of a Safety/Health Rule, Regulation, Procedure or Specific Instruction?

Was the Employee Properly Instructed and/or Trained (Please describe):

What corrective measures are being taken to prevent similar accidents?

Signed:

Supervisor:	Phone:	Date:
Supervisor Email address:		
Department Head:	Phone:	Date:
Department Head Email address:		

Appendix C

Attach Non-Employee, Visitor, Volunteer Injury Report forms here

- Non-Employee, Visitor, Volunteer Injury Report Form
- Accident Investigation Witness Statements
- Supervisors Report of Accident Investigation

WARREN COUNTY
NON-EMPLOYEE, VISITOR, VOLUNTEER INJURY REPORT

INJURED PERSON COMPLETES:

DATE OF INCIDENT: _____ TIME: _____

LOCATION OF INCIDENT: _____

INJURED NAME: _____ AGE: _____ PHONE: _____

ADDRESS: _____

DESCRIBE WHAT YOU WERE DOING JUST BEFORE THE INCIDENT AND WHAT HAPPENED:

DESCRIBE YOUR INJURIES: _____

TAKEN TO HOSPITAL? _____ DOCTOR? _____

SIGNATURE: _____ DATE: _____

If this form was completed by someone other than the injured person please complete:

Name of person completing report: _____ Phone: _____

Relationship to injured: _____

Signature: _____ Date: _____

Provide this form to your supervisor or the supervisor of the physical area where you were injured.

Supervisor, make sure to obtain "Witness Statements" and complete the "Supervisors Report of Investigation Form" that follows this page.

Accident Investigation Witness Statement

Personal Information (make additional copies of this form as needed)

Name of Witness		
Address		
City, State, Zip		
Phone		

Accident Information

Injured Persons Name:		Date and Time of Accident	
Location of accident		Weather Conditions at time of Accident	

In your words, give a brief description of the accident:

--

How did the Injury Occur?

--

How Could the Accident Have Been Prevented?

--

Signed:

Witness Name		Date
--------------	--	------

**Supervisor's Report of Accident Investigation
Supplement Non-employee, Visitor, Volunteer Injury Report Form**

Date of Investigation:	Investigator:
Injured Person:	

Describe the accident in detail (include physical surroundings, equipment in use)

SPECIFY THE UNSAFE ACTS AND CONDITIONS WHICH LED TO THE ACCIDENT (Please circle all that apply):

- | | |
|--|---|
| <ul style="list-style-type: none"> • Improper lifting, carrying, handling • Improper use of tools or equipment • Operating without authority • Failure to wear personal protective equipment • Failure to use safety devices • Failure to use proper tools/equipment • Failure to obey rules/procedures • Failure to secure ladders • Lack of adequate training | <ul style="list-style-type: none"> • Transitioning to/from ladder • Misstep on ladder • Over-reaching on ladder • Using defective equipment • Overriding safety devices • Horseplay • Taking shortcuts or hurrying • Action of others • Other: _____ |
|--|---|

**Supervisor's Report of Accident Investigation
Supplement Non-employee, Visitor, Volunteer Injury Report- Page 2**

Unsafe Conditions:

- | | |
|--|---|
| <ul style="list-style-type: none"> • Wet and/or slippery working surface • Defective floor and/or walking area • Congested work area • Poor housekeeping • Inadequate lighting • Inadequate guards • Inadequate design or maintenance | <ul style="list-style-type: none"> • Lack of available personal protective equip • Lack of proper tools or equipment • Defective tools or equipment • Inadequate warning system • Projection hazards • Hazardous atmosphere • Other: _____ |
|--|---|

Personal Factors:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Improper work habits • Unaware of work hazard • Improper motivation | <ul style="list-style-type: none"> • Improper attire • Improper attitude • Unwilling to follow work rules • Other: _____ |
|---|--|

Was there an infraction of a Safety/Health Rule, Regulation, Procedure or Specific Instruction?

Was the injured Properly Instructed and/or Trained (Please describe):

What corrective measures are being taken to prevent similar accidents?

Signed:

Supervisor:	Phone:	Date:
Supervisor Email address:		
Department Head:	Phone:	Date:
Department Head Email address:		
Department Head should immediately fax this form to the County Attorney at 761-6377 and Self-Insurance at 761-6249 and mail the original to the County Attorney.		

Appendix D

Attach Near Miss Incident Report forms here

- Near Miss Accident/Incident Report Form
- Accident Investigation Witness Statement
- Supervisors Report of Accident Investigation

Near Miss Accident/Incident Report

This form is to be used to report near-miss incidents/accidents, which did not, but could have resulted in personal injury or loss to an employee or the company.

Date of Incident	Location of Incident:
Time of Incident:	Department:
Work Area:	Area Supervisor:

Employees and/or Visitors Involved:

Name	Department/Location or Address

Describe the incident in detail (include physical surroundings, equipment in use)

--

In your opinion, what caused the incident?

--

In your opinion, what can be done to prevent a recurrence?

--

What corrective action have you taken?

--

Signed:

Name:	Phone:	Date:
-------	--------	-------

Accident Investigation Witness Statement

Personal Information

Name of Witness			
Address			
City, State, Zip			
Phone			

Employment Information

Department		Work Site	
Occupation		Supervisor	
Date of Hire		Time in current position	

Accident Information – Injured Person’s Name: _____

Date accident occurred		Time of Accident	
Location of accident		Weather Conditions at time of Accident	

In your words, give a brief description of the accident:

How did the Injury Occur?

How Could the Accident Have Been Prevented?

Signed:

Witness
Name _____

Date

Supervisor's Report of Accident Investigation Supplement to Near Miss Report

Date of Investigation:	Investigator:
Injured Person:	

Describe the accident in detail (include physical surroundings, equipment in use)

SPECIFY THE UNSAFE ACTS AND CONDITIONS WHICH LED TO THE ACCIDENT (Please circle all that apply):

Unsafe Acts:

<ul style="list-style-type: none"> • Improper lifting, carrying, handling • Improper use of tools or equipment • Operating without authority • Failure to wear personal protective equipment • Failure to use safety devices • Failure to use proper tools/equipment • Failure to obey rules/procedures • Failure to secure ladders • Lack of adequate training 	<ul style="list-style-type: none"> • Transitioning to/from ladder • Misstep on ladder • Over-reaching on ladder • Using defective equipment • Overriding safety devices • Horseplay • Taking shortcuts or hurrying • Action of others • Other: _____
--	---

Unsafe Conditions:

<ul style="list-style-type: none"> • Wet and/or slippery working surface • Defective floor and/or walking area • Congested work area • Poor housekeeping • Inadequate lighting • Inadequate guards • Inadequate design or maintenance 	<ul style="list-style-type: none"> • Lack of available personal protective equip • Lack of proper tools or equipment • Defective tools or equipment • Inadequate warning system • Projection hazards • Hazardous atmosphere • Other: _____
--	---

Supervisor's Report of Accident Investigation Supplement to Near Miss Report – Page 2

Personal Factors:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Improper work habits • Unaware of work hazard • Improper motivation | <ul style="list-style-type: none"> • Improper attire • Improper attitude • Unwilling to follow work rules • Other: _____ |
|---|--|

Was there an infraction of a Safety/Health Rule, Regulation, Procedure or Specific Instruction?

Was the Employee Properly Instructed and/or Trained (Please describe):

What corrective measures are being taken to prevent similar accidents?

Signed:

Supervisor:	Phone:	Date:
Supervisor Email address:		
Department Head:	Phone:	Date:
Department Head Email address:		

Appendix E

Attach Property Damage Report forms here

- Property Damage Report Form
- Accident Investigation Witness Statements
- Supervisors Report of Accident Investigation

Property Damage Report

Department/Facility:	Report Submitted By:
Date of Damage:	Time: a.m. p.m.
Address of Incident:	
Equipment or Structure Damaged (<i>include equipment number if appropriate</i>):	
Describe Damage:	

Damage Caused By Natural Event: (Please check if appropriate)

Wind <input type="checkbox"/>	Ice <input type="checkbox"/>	Snow <input type="checkbox"/>	Water <input type="checkbox"/>	Lightning <input type="checkbox"/>
-------------------------------	------------------------------	-------------------------------	--------------------------------	------------------------------------

Damage Caused By Human Error: (Please check if appropriate)

<i>Operating Unsafe Equipment</i> <input type="checkbox"/>	Lack of or inadequate training <input type="checkbox"/>	Lack of experience <input type="checkbox"/>	Careless/ Irresponsible Attitude <input type="checkbox"/>
<i>Failure to follow instruction</i> <input type="checkbox"/>	Other: (please specify) <input type="checkbox"/>		

Damage Caused by Equipment/Structural Failure (Please state cause)

Property Damage Report Page 2

Personnel Information (Must be given in all cases involving an employee in the incident)

Name:	Department:
Employee Account of Incident:	
Action taken to prevent recurrence:	

SUPERVISOR TO COMPLETE

Action taken to repair or replace customer's property or belongings:	
Direct Costs of Repair/Replacement:	
Mechanical \$	Electrical \$
Structural \$	Vehicular \$
Property \$	Other (specify) \$
Total Direct Cost Loss Incurred from Incident \$	
Estimated Indirect Costs Associated with Incident:	
Product Loss \$	Equipment Rental \$
Administrative/Investigative \$	Insurance Deductibles \$
Other (List) \$	Other (List) \$
Total Indirect Cost Loss Incurred from Incident \$	

Please attach additional pages for sketches and diagrams of the incident scene as appropriate.

SIGNED:

Employee:	Phone:	Date:
Supervisor:	Phone:	Date:
Department Head:	Phone:	Date:

Fax to County Attorney 761-6377, mail original to Co. Attorney. Fax copy to Self-Insurance 761-6249

Accident Investigation Witness Statement

Personal Information

Name of Witness			
Address			
City, State, Zip			
Phone			

Employment Information

Department		Work Site	
Occupation		Supervisor	
Date of Hire		Time in current position	

Accident Information – Injured Person's Name: _____

Date accident occurred		Time of Accident	
Location of accident		Weather Conditions at time of Accident	

In your words, give a brief description of the accident:

How did the Injury Occur?

How Could the Accident Have Been Prevented?

Signed:

Witness Name		Date	
--------------	--	------	--

Supervisor's Report of Accident Investigation Supplement to Property Damage Report

Date of Investigation:	Investigator:
Property Damaged:	

Describe the accident in detail (include physical surroundings, equipment in use)

Employee(s) involved: _____

SPECIFY THE UNSAFE ACTS AND CONDITIONS WHICH LED TO THE ACCIDENT (Please circle all that apply):

Unsafe Acts:

<ul style="list-style-type: none"> • Improper lifting, carrying, handling • Improper use of tools or equipment • Operating without authority • Failure to wear personal protective equipment • Failure to use safety devices • Failure to use proper tools/equipment • Failure to obey rules/procedures • Failure to secure ladders • Lack of adequate training 	<ul style="list-style-type: none"> • Transitioning to/from ladder • Misstep on ladder • Over-reaching on ladder • Using defective equipment • Overriding safety devices • Horseplay • Taking shortcuts or hurrying • Action of others • Other: _____
--	---

Unsafe Conditions:

<ul style="list-style-type: none"> • Wet and/or slippery working surface • Defective floor and/or walking area • Congested work area • Poor housekeeping • Inadequate lighting • Inadequate guards • Inadequate design or maintenance 	<ul style="list-style-type: none"> • Lack of available personal protective equip • Lack of proper tools or equipment • Defective tools or equipment • Inadequate warning system • Projection hazards • Hazardous atmosphere • Other: _____
--	---

Supervisor's Report of Accident Investigation Supplement to Property Damage Report- Page 2

Personal Factors:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Improper work habits • Unaware of work hazard • Improper motivation | <ul style="list-style-type: none"> • Improper attire • Improper attitude • Unwilling to follow work rules • Other: _____ |
|---|--|

Was there an infraction of a Safety/Health Rule, Regulation, Procedure or Specific Instruction?

Was the Employee Properly Instructed and/or Trained (Please describe):

What corrective measures are being taken to prevent similar accidents?

Signed:

Supervisor:	Phone:	Date:
Supervisor Email address:		
Department Head:	Phone:	Date:
Department Head Email address:		

Appendix F

Attach Automobile Loss Report forms here

- Automobile Loss Report Form
- Accident Investigation Witness Statements
- Supervisors Report of Accident Investigation

AUTOMOBILE LOSS REPORT

(Use this form to report incidents involving County automobiles.)

NAME OF INSURED: WARREN COUNTY

DATE OF ACCIDENT: _____ TIME: _____ LOCATION: _____

COUNTY VEHICLE (YR & MAKE): _____ VIN# _____

PRESENT LOCATION OF VEHICLE: _____

OPERATOR OF COUNTY VEHICLE: _____ PHONE: _____ AGE: _____

OPERATORS ADDRESS: _____

DESCRIPTION OF ACCIDENT: _____

AREA OF DAMAGE ON COUNTY VEHICLE: _____

OTHER VEHICLE

OTHER VEHICLE (YR & MAKE): _____ PLATE #: _____

OWNER(NAME, ADDRESS, PHONE): _____

DRIVER (NAME, ADDRESS, PHONE): _____

OTHER AGENT OR INSURANCE CO (NAME, ADDRESS, PHONE): _____

AREA OF DAMAGE ON OTHER VEHICLE: _____

INJURIES

NAME: _____ AGE: _____ PHONE: _____

ADDRESS: _____

INJURY: _____

NAME: _____ AGE: _____ PHONE: _____

ADDRESS: _____

INJURY: _____

WITNESSES (All witnesses complete appendix C attached)

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

POLICE DEPT: _____ TICKETS ISSUED: _____

OTHER COMMENTS: _____

REPORT COMPLETED BY: _____ DATE: _____

CONTACT PHONE NUMBER: _____

Department supervisor should immediately fax this form to the County Attorney at 761-6377 and mail the original to the County Attorney. Department should also fax this form to Self-Insurance at 761-6249. (If County Employee was injured, see procedure to report employee injuries at www.warrencountyny.gov/insurance.)

Accident Investigation Witness Statement

Personal Information

Name of Witness			
Address			
City, State, Zip			
Phone			

Employment Information

Department		Work Site	
Occupation		Supervisor	
Date of Hire		Time in current position	

Accident Information – Injured Person's Name: _____

Date accident occurred		Time of Accident	
Location of accident		Weather Conditions at time of Accident	

In your words, give a brief description of the accident:

How did the Injury Occur?

How Could the Accident Have Been Prevented?

Signed:

Witness Name		Date	
--------------	--	------	--

Supervisor's Report of Accident Investigation Supplement to Automobile Loss Report

Date of Investigation:

Investigator:

Property Damaged:

Describe the accident in detail (include physical surroundings, equipment in use)

Employee(s) involved: _____

SPECIFY THE UNSAFE ACTS AND CONDITIONS WHICH LED TO THE ACCIDENT (Please circle all that apply):

Unsafe Acts:

- | | |
|--|--|
| <ul style="list-style-type: none">• Operating without authority• Failure to wear personal protective equipment• Failure to use safety devices• Failure to use proper tools/equipment• Failure to obey rules/procedures• Failure to secure cargo• Lack of adequate training | <ul style="list-style-type: none">• Using defective equipment• Overriding safety devices• Horseplay• Taking shortcuts or hurrying• Action of others• Other: _____ |
|--|--|

Unsafe Conditions:

- | | |
|--|--|
| <ul style="list-style-type: none">• Congested area• Poor housekeeping• Inadequate lighting• Inadequate design or maintenance• Lack of available personal protective equip• Lack of proper equipment | <ul style="list-style-type: none">• Defective equipment• Inadequate warning system• Projection hazards• Hazardous atmosphere• Other: _____ |
|--|--|

Supervisor's Report of Accident Investigation Supplement to Automobile Loss Report- Page 2

Personal Factors:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Improper work habits • Unaware of work hazard • Improper motivation | <ul style="list-style-type: none"> • Improper attire • Improper attitude • Unwilling to follow work rules • Other: _____ |
|---|--|

Was there an infraction of a Safety/Health Rule, Regulation, Procedure or Specific Instruction?

Was the Employee Properly Instructed and/or Trained (Please describe):

What corrective measures are being taken to prevent similar accidents?

Signed:

Supervisor:	Phone:	Date:
Supervisor Email address:		
Department Head:	Phone:	Date:
Department Head Email address:		

Appendix G

Attach Incident Tracking Log here



Warren County Self-Insurance
INCIDENT TRACKING LOG

Use this form to record employee incidents that happened while at work but did not result in any lost time or any medical treatment. If in the future the employee seeks medical treatment or misses work the proper forms for reporting a workplace injury must be completed.

Municipality: _____

Department: _____ For the year: _____

Employee Name: _____ Date and Time of Incident: _____

Nature of injury (if any): _____

What was the employee doing when the incident occurred: _____

What happened to injure or nearly injure the employee: _____

Is this incident related to work? _____ Supervisor of employee: _____

Person Completing this form: _____ Date: _____

Employee Name: _____ Date and Time of Incident: _____

Nature of injury (if any): _____

What was the employee doing when the incident occurred: _____

What happened to injure or nearly injure the employee: _____

Is this incident related to work? _____ Supervisor of employee: _____

Person Completing this form: _____ Date: _____

Employee Name: _____ Date and Time of Incident: _____

Nature of injury (if any): _____

What was the employee doing when the incident occurred: _____

What happened to injure or nearly injure the employee: _____

Is this incident related to work? _____ Supervisor of employee: _____

Person Completing this form: _____ Date: _____

Warren County Board of Supervisors

RESOLUTION NO. 484 OF 2014

Resolution introduced by Supervisors Taylor, McDevitt, Frasier, Vanselow, Wood, Brock and Seeber

APPROVING REVISIONS AND AMENDMENTS TO THE WARREN COUNTY EMERGENCY ACTION AND RESPONSE PLAN, HUMAN SERVICES EMERGENCY ACTION PLAN, PLAN AND PROGRAM ON WORKPLACE HARASSMENT, SAFETY AND HEALTH PROGRAM POLICY, AND INCIDENT MANAGEMENT GUIDELINES

WHEREAS, the Self-Insurance Administrator periodically reviews and updates the various Warren County safety and risk management policies, and

WHEREAS, the Warren County Support Services Committee recommends the revisions and amendments proposed by the Self-Insurance Administrator to the various safety and risk policies as outlined below, now, therefore, be it

RESOLVED, that the Warren County Board of Supervisors hereby approve the revisions and amendments made by the Warren County Self-Insurance Administrator to the various safety policies as summarized below:

Warren County Emergency Action and Response Plan:

Changes are housekeeping in nature (i.e. changed individual names to titles) and appropriate language has been added in reference to the National Incident Management System. Various forms are kept in appendices so that they can be revised without revising the entire policy.

Human Services Emergency Action Plan:

Changes are housekeeping in nature (i.e. changed individual names to titles) and appropriate language has been added in reference to the National Incident Management System.

Plan and Program on Workplace Harassment:

Changes the reference from "Personnel" to "Human Services".

Safety and Health Program Policy:

Policy now combines prior Resolution Nos. 557 of 2009 and 279 of 2009 that set the format of the safety committees and more accurately reflects the functions of the safety committees. The proposed policy also includes a Hazard Identification checklist that will be used to inspect facilities for hazards.

→ Incident Management Guidelines:

Changes have been made to more clearly identify the forms that must be prepared when an incident occurs. The forms are mandatory appendices for easy reference and revision as needed, and be it further

RESOLVED, that the changes are hereby approved as made to each of the above stated policies, and copies of each shall be maintained on file with the Clerk of the Warren County Board of Supervisors.