

CITY OF EUREKA

Category: PERSONNEL

POLICIES & PROCEDURES

Subject: REPORTING  
ACCIDENTS/PERSONAL INJURY

Date Adopted: May 1, 1972

File 3.70

Date Revised: December 1, 1979

Number

### POLICY OBJECTIVE

To protect the City from unnecessary liability resulting from vehicular accidents while employee is on duty, driving a vehicle, to protect the City from unnecessary liability for property damage caused by a City employee, to ensure accurate and necessary reporting of on-duty injuries and to protect City-owned equipment from unwarranted abuse while in use.

### ASSIGNED RESPONSIBILITY

All Department Heads and Supervisors.

### APPLICABILITY

Applicable to all City employees and officers, Department Heads, Supervisors and City Safety Committee Members when personnel are involved in personal injury, property damage, vehicular accident or abuse of City equipment while on duty.

### PROCEDURES

SEE ATTACHED MEMORANDUM AND EXAMPLES FOR REPORTING INJURIES

# MEMORANDUM

**To:** ALL DEPARTMENT HEADS, SUPERVISORS, AND  
ADMINISTRATIVE SUPPORT EMPLOYEES  
**From:** SUSAN CHRISTIE, PERSONNEL MANAGER *SUSAN*  
**Date:** JANUARY 27, 2004  
**Subject:** UPDATED PROCEDURES/FORMS FOR REPORTING  
ACCIDENTS

Attached are updated guidelines for reporting accidents. The instructions now also include required phone notifications, as appropriate and timely notifications are critical in a risk management program. The sooner notifications are made, the better the outcome for all concerned. If there is any doubt about whether something should be reported by phone at the time it occurs, err on the side of caution and report it.

There are four categories in this handout:

1. Employee Injury
2. Equipment/Vehicle/Property Damage
3. Other Claims Of Injury/Property Damage From A Member Of The Public
4. Reporting "Near Misses"

Each of the four sections is color-coded, and sample completed forms are included for your reference. Also provided are blank copies of the forms for your use. You may make copies of the forms (except the NCR) as needed or obtain more from the Personnel Department.

Please make sure those employees who oversee the completion of these forms are aware of this update, and replace past versions with the current information.

If you have any questions or clarifications about the information provided in this handout, please contact our office at 441-4124. Thank you for your attention to this essential component of our risk management program.

EXHIBIT #1  
EMPLOYEE INJURY

**OBVIOUSLY, THE REPORTING REQUIREMENTS FOR EMPLOYEE INJURIES AND ILLNESSES CARRY THE MOST COMPREHENSIVE REPORTING REQUIREMENTS. PLEASE CAREFULLY READ THE INFORMATION IN "A" BELOW ON ALL NECESSARY NOTIFICATIONS.**

A. PROCEDURE FOR APPROPRIATE NOTIFICATIONS:

1. IF, AS A RESULT OF A WORK-RELATED INJURY, AN EMPLOYEE (1) RECEIVES EMERGENCY MEDICAL AID (AMBULANCE); OR (2) IS HOSPITALIZED; OR (3) DIES, THE FOLLOWING **IMMEDIATE** NOTIFICATIONS ARE NECESSARY:

**IF DURING NORMAL BUSINESS HOURS**, CONTACT THE PERSONNEL DEPARTMENT AT 707-441-4124.

**IF NOT DURING NORMAL BUSINESS HOURS**, CONTACT CAL NORTH (JIM CASH) AT 707-443-5302 (OFFICE); 707-269-8870 (PAGER); OR 707-443-9007 (HOME). ALSO NOTIFY THE PERSONNEL DEPARTMENT BY VOICE MAIL MESSAGE AT 707-441-4124.

**NOTE**: ANY CITY EMPLOYEE CAN MAKE THESE NOTIFICATIONS, WHICH ARE VITAL FOR INSURING INJURED EMPLOYEES RECEIVE ALL OF THE MEDICAL CARE AND BENEFITS TO WHICH THEY ARE ENTITLED.

2. **IN ADDITION**, IF AN EMPLOYEE (1) SUFFERS A "SERIOUS INJURY OR ILLNESS" WHICH REQUIRES HOSPITALIZATION FOR OTHER THAN OBSERVATION FOR LONGER THAN 24 HOURS; OR (2) SUFFERS THE LOSS OF ANY BODY PART; OR (3) SUFFERS ANY SERIOUS DEGREE OF PERMANENT DISFIGUREMENT; OR (4) DIES, **CAL OSHA MUST BE NOTIFIED** BY PHONE OR FAX **WITHIN 8 HOURS** OF WHEN THE EMPLOYER KNEW OR SHOULD HAVE KNOWN OF THE EMPLOYEE'S CONDITION. THIS NOTIFICATION IS TO BE MADE BY THE FIRST SUPERVISOR WITHIN THE CHAIN OF COMMAND WHO BECOMES AWARE OF THE EMPLOYEE'S CONDITION. IF IT IS NOT POSSIBLE FOR A SUPERVISOR TO MAKE THE NOTIFICATION WITHIN 8 HOURS, THE NEXT SENIOR EMPLOYEE TO THE INVOLVED EMPLOYEE IS TO MAKE THE NOTIFICATION.

IF THE **CITY'S FIRE DEPARTMENT OR POLICE DEPARTMENT** HAS RESPONDED TO AN INCIDENT AS DESCRIBED IN THE ABOVE PARAGRAPH, A REPRESENTATIVE FROM EACH RESPONDING DEPARTMENT IS ALSO REQUIRED TO NOTIFY CAL OSHA OF THE EMPLOYEE'S CONDITION BY TELEPHONE.

THE **CAL OSHA NOTIFICATION NUMBERS** FOR THE REDDING DISTRICT OFFICE ARE 530-224-4743 (PHONE) AND 530-224-4747 (FAX). THE **INFORMATION TO BE PROVIDED** IS (1) TIME AND DATE OF ACCIDENT; (2) EMPLOYER'S NAME, ADDRESS, AND TELEPHONE NUMBER; (3) NAME AND JOB TITLE (AND BADGE #

EXHIBIT #1

EMPLOYEE INJURY (CONT.)

3. IF AVAILABLE AT TIME OF COMPLETION OF FORMS, ANY DOCTOR'S OR EMERGENCY ROOM SLIPS OR REPORTS SHOULD BE INCLUDED WITH THE ABOVE FORMS.
4. **ALL FORMS MUST BE SUBMITTED TO PERSONNEL WITHIN TWENTY-FOUR (24) HOURS OF THE OCCURRENCE.** LATE SUBMISSION OF THESE FORMS TO REMIF COULD RESULT IN THE CITY BEING FINED. IF IT IS FOUND THAT THE DELAY OCCURRED AT THE DEPARTMENT LEVEL, ANY FINES LEVIED WILL BE DEDUCTED FROM DEPARTMENT FUNDS.

E. **PROCEDURE FOR FILLING OUT THE TIMECARD FOR TIME MISSED DUE TO AN EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS:**

1. ALWAYS MARK THE TIME MISSED "WC" FOR WORKERS' COMPENSATION, REGARDLESS OF WHETHER PAPERWORK HAS BEEN SUBMITTED OR WHETHER THE CLAIM HAS BEEN ACCEPTED YET OR NOT. THIS ALERTS PAYROLL AND PERSONNEL TO THE FACT THAT A WORK-RELATED INJURY/ILLNESS HAS BEEN REPORTED (EXHIBIT 1C).
2. PLEASE IDENTIFY THE TYPE OF INJURY BEING CLAIMED BY PUTTING A "WC=" [TYPE OF INJURY]" DIRECTLY ON THE TIMECARD (EXHIBIT 1C).

# (EXHIBIT IA)

State of California  
Department of Industrial Relations  
DIVISION OF WORKERS' COMPENSATION



Estado de California  
Departamento de Relaciones Industriales  
DIVISION DE COMPENSACIÓN AL TRABAJADOR

## EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.**

## PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la División de Compensación al Trabajador llamando al 1-800-736-7401. En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

**Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".**

Employee: Empleado: JOHN DOE

1. Name. Nombre. JOHN DOE Today's Date. Fecha de hoy. 07-1-97

2. Home Address. Dirección Residencial. 55555 DOE LANE

3. City. Ciudad. EUREKA State. Estado. CA Zip. Código Postal. 95501

4. Date of Injury. Fecha de la lesión (accidente). 07-1-97 Time of Injury. Hora en que ocurrió. 8:30 a.m. \_\_\_\_\_ p.m.

5. Address and description of where injury happened. Dirección/lugar dónde ocurrió el accidente. I WAS LIFTING A BOX OF PAMPHLETS AT CITY HALL, 531 K STREET, IN THE BASEMENT.

6. Describe injury and part of body affected. Describa la lesión y parte del cuerpo afectada. AS I LIFTED THE BOX, I FELT PAIN IN THE MIDDLE OF MY LOWER BACK.

7. Social Security Number. Número de Seguro Social del Empleado. 000-00-0000

8. Signature of employee. Firma del empleado. John Doe

Employer - complete this section and give the employee a copy immediately as a receipt.  
Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. Nombre del empleador. CITY OF EUREKA, CA

10. Address. Dirección. 531 K STREET, EUREKA, CA 95501

11. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. 07-01-97

12. Date claim form was provided to employee. Fecha en que se le entregó al empleado la petición. 07-01-97

13. Date employer received claim form. Fecha en que el empleado devolvió la petición al empleador. 07-01-97

14. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. REMIE, P O BOX 885, SONOMA, CA 95476

15. Insurance Policy Number. El número de la póliza del Seguro. N/A

16. Signature of employer representative. Firma del representante del empleador. (SUPERVISOR OR DEPT. HEAD)

17. Title. Título. \_\_\_\_\_ 18. Telephone. Teléfono. \_\_\_\_\_

Employer: You are required to date this form and provide copies to your insurer or claim administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

Empleador: Se requiere que Ud. feche esta forma y que provea copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

# (EXHIBIT 13)

FORWARD TO PERSON RESPONSIBLE FOR FILING FIRST REPORT OF INJURY - PERSONNEL DEPARTMENT

Department <b>SUPPLIES</b>		IMMEDIATE SUPERVISOR'S REPORT OF EMPLOYEE INJURY (Please Complete In Detail)			
Name of Injured <b>JOHN DOE</b>		Age <b>18</b>	Married? <b>NO</b>	Male <input checked="" type="checkbox"/>	Female <input type="checkbox"/>
Date of Accident <b>07-01-97</b>	Hour <b>8:30</b>	(a.m.) <input checked="" type="checkbox"/>	(p.m.) <input type="checkbox"/>	Job Title <b>SUPPLY OFFICER</b>	
Nature of Injury <b>HURT MIDDLE OF LOWER BACK WHILE LIFTING BOX</b>					
Who gave First Aid, if any? <b>N/A</b>		Names of Witnesses <b>JANE SMITH, PETER JONES</b>			
Name and address of physician seen for this injury/illness: <b>DR. PHYSICIAN</b>		<b>0000 ROADS STREET EUREKA, CA 95501</b>		Was injured acting in regular line of duty? <b>YES</b>	
Did injured leave work? <b>YES</b>	Date <b>07-01-97</b>	Time <b>9:00</b>		(a.m.) <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	
Did injured return to work? <b>YES</b>	Date <b>07-01-97</b>	Time <b>11:30</b>		(a.m.) <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	

Describe the accident and where it occurred

**JOHN WAS IN THE CITY HALL BASEMENT OBTAINING A BOX OF PAMPHLETS TO BRING TO THE 2ND FLOOR. WHILE LIFTING THE BOX, HE FELT PAIN IN THE MIDDLE OF HIS LOWER BACK.**

## IMMEDIATE SUPERVISOR'S EVALUATION

Analysis of Accident Please mark the reasons that, in your opinion, caused the accident. In most cases there will be several reasons under both unsafe conditions and unsafe acts contributing to the accident. Fill out in detail.

- AN UNSAFE CONDITION EXISTED (Check all that apply)
- Defective equipment - tools
  - Equipment not properly guarded
  - Poor working conditions (light, ventilation)
  - Other (specify)
  - Slippery or uneven walking surfaces
  - Faulty layout of facilities
  - Poor housekeeping

What have you done to eliminate this condition?

- AN UNSAFE ACT RESULTED FROM (Check all that apply)
- Lack of training
  - Not following rules
  - Haste; chance taking
  - Other (specify)
  - Not using personal safety devices
  - Physical or mental handicap
  - Boredom; inattention
  - Horseplay
  - Improper work method
  - Improper body position

What have you done to correct this act? **JOHN ADMITS HE WAS IN A HURRY AND DID NOT USE THE DULY TO LIFT THIS BOX ACCORDING TO ESTABLISHED PROCEDURE. HE HAS**

AGREED TO PERFORM THIS DUTY AS PREVIOUSLY INSTRUCTED IN THE FUTURE.  
Employee Usually Works 8 Hours per Day 5 Days Per Week Employee began work at 8:00 a.m. \_\_\_\_\_ p.m.

Date injured worker given claim form <b>07-01-97</b>	Time <b>8:45 A.M.</b>
Supervisor's signature	Dept. Head signature
Date of report <b>07-01-97</b>	Dept. Safety Officer



EXHIBIT #2  
EQUIPMENT/VEHICLE/PROPERTY DAMAGE

A. PROCEDURE FOR APPROPRIATE NOTIFICATIONS:

IF (1) AN ACCIDENT HAS OCCURRED BETWEEN A CITY VEHICLE AND A MEMBER OF THE PUBLIC, OR (2) PROPERTY DAMAGE HAS OCCURRED TO PRIVATE PROPERTY OF ANY TYPE, **AND** THE FOLLOWING APPLIES, NOTIFICATIONS ARE NECESSARY AS DESCRIBED BELOW:

1. SOMEONE INVOLVED IN AN ACCIDENT RECEIVES EMERGENCY MEDICAL AID (AMBULANCE); OR (B) IS HOSPITALIZED; OR (C) DIES;
2. PROPERTY DAMAGE HAS OCCURRED THAT COULD BE CONSIDERED "MAJOR," AND/OR A PROPERTY OWNER IS PRESENT AND EXPRESSING CONCERNS ABOUT THE DAMAGE.

IF DURING NORMAL BUSINESS HOURS, CONTACT JEFF DAVIS AT REMIF AT 707-938-2388, EXT. 11.

IF NOT DURING NORMAL BUSINESS HOURS OR IF UNABLE TO REACH REMIF, CONTACT CAL NORTH (JIM CASH) AT 707-443-5302 (OFFICE); 707-269-8870 (PAGER); OR 707-443-9007 (HOME).

**NOTE:** ANY CITY EMPLOYEE CAN MAKE THESE NOTIFICATIONS, WHICH ARE VITAL FOR APPROPRIATE CITY RISK MANAGEMENT.

B. FORMS TO BE COMPLETED (COPIES ATTACHED):

1. ACCIDENT/REPORT FORM
2. ACCIDENT/INCIDENT INVESTIGATION REPORT

C. PROCEDURE FOR COMPLETING FORMS:

1. THE AFFECTED OR REPORTING EMPLOYEE COMPLETES THE ACCIDENT REPORT FORM (EXHIBIT 2A) AND SECTION I OF THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM (EXHIBIT 2B).
2. THE ACCIDENT REPORT FORM IS FORWARDED TO THE SUPERVISOR/DEPARTMENT HEAD FOR REVIEW AND SIGNATURE. THE COMPLETED FORM IS SENT TO THE CITY ATTORNEY'S OFFICE.
3. THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM IS FORWARDED TO THE DEPARTMENT'S DESIGNATED ACCIDENT INVESTIGATOR. BASED ON THE ABOVE INFORMATION (AND ANY OTHER AVAILABLE), THE ACCIDENT INVESTIGATOR COMPLETES SECTION II OF THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM, AND REFERS THE FORM TO THE SUPERVISOR/DEPARTMENT HEAD FOR REVIEW AND SIGNATURES. THIS FORM MUST BE **SENT TO PERSONNEL WITHIN ONE WEEK** OF THE OCCURRENCE.

CITY OF EUREKA  
ACCIDENT REPORT FORM

(EXHIBIT 2A)

THIS REPORT MUST BE COMPLETED, DELIVERED, AND FILED IN TRIPPLICATE WITH THE CITY ATTORNEY'S OFFICE  
VIA DEPARTMENT HEAD, IMMEDIATELY AFTER AN ACCIDENT.

ALL ACCIDENTS OR INCIDENTS INVOLVING INJURY TO PERSONS, (FOR INJURY TO CITY EMPLOYEES IN THE LINE  
OF DUTY USE "EMPLOYEE'S CLAIM FOR WORKER'S COMPENSATION BENEFITS" FORM AVAILABLE FROM SUPERVISOR,  
OR PERSONNEL), AND DAMAGE TO PROPERTY OCCURRING ON, OR AS A RESULT OF, THE OPERATION OF CITY OWNED  
PROPERTY OR CITY ACTIVITIES, ARE TO BE REPORTED ON THIS FORM.

TYPE OR PRINT ALL INFORMATION: (IF INADEQUATE SPACE USE REVERSE SIDE).

1. CITY EMPLOYEE MAKING REPORT: NAME JOHN DOE DEPARTMENT SUPPLIES DIVISION N/A

2. PLACE OF ACCIDENT: 00 SMITH STREET DATE OF ACCIDENT: 07-01-97 TIME OF ACCIDENT: 3:00 P.M.  
EUREKA

3. VEHICLE ACCIDENT:  
A. CITY VEHICLE #, USING DEPT. AND DESCRIPTION # 000, SUPPLIES, 1990 CHEVY ROADSTER

CITY VEHICLE DAMAGED? YES X NO      DESCRIBE DAMAGE TO CITY VEHICLE R FRONT FENDER SMASHED

B. OTHER VEHICLE: MAKE/MODEL 1985 FORD SPEEDSTER YEAR 1985 LICENSE# ABC000

OTHER VEHICLE DAMAGED? YES X NO      DESCRIBE DAMAGE TO OTHER VEHICLE DRIVER'S DOOR DENTED IN

OPERATOR OF OTHER VEHICLE: NAME JIM JAMES ADDRESS 0000 JOHN STREET EUREKA

TELEPHONE 000-0000 OPERATOR'S LICENSE # CAE 0000000

4. INJURED: (NAME AND ADDRESS)

JIM JAMES AGE 62  
AGE     

5. NON-VEHICULAR ACCIDENTS:

BRIEFLY DESCRIBE PROPERTY DAMAGE, IF ANY: DUMPSTER AT CORNER OF SMITH AND JONES  
STREET HIT STOP SIGN AND BROKE IT IN TWO ABOUT HALFWAY DOWN SUPPORT POLE.

DESCRIBE INJURIES, IF ANY, AND LIST INJURED ABOVE: MR. JAMES SUSTAINED A  
DEEP CUT ABOVE HIS RIGHT EYE

BRIEFLY DESCRIBE HOW ACCIDENT OCCURRED: JOHN WAS ATTEMPTING TO TURN RIGHT ONTO  
JONES STREET FROM SMITH STREET. MR. JAMES WAS TURNING LEFT FROM JONES  
TO SMITH AND CUT THE CORNER TOO SHARPLY. THE RIGHT FRONT FENDER OF  
CITY VEHICLE #000 HIT THE DRIVER'S DOOR OF MR. JAMES'S VEHICLE. THE IMPACT  
OF THE TWO CARS PUSHED CITY VEHICLE #000 INTO THE DUMPSTER, WHICH HIT AND

WITNESSES: (LIST NAME(S) AND ADDRESS(ES)) BROKE THE STOP SIGN.

A) JUST STANDING AROUND, 000 BORING STREET, EUREKA, 95503  
B) HAPPENED TO SEE IT, 0000 LUCKY LANE, EUREKA, 95501

POLICE INVESTIGATION: YES X NO     

SIGNATURE OF CITY EMPLOYEE:

John Doe  
SIGNATURE

07-01-97 4:00 P.M.  
DATE AND TIME

NOTED BY DEPARTMENT OR DIVISION HEAD:

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE AND TIME

DO NOT ADMIT LIABILITY. DO NOT DISCUSS THE ACCIDENT OR INCIDENT WITH ANYONE EXCEPT YOUR  
DEPARTMENT OR DIVISION HEAD, AND THE CITY ATTORNEY. SUPPLY THE POLICE WITH YOUR DRIVER'S LICENSE  
NO., THE NAME OF YOUR EMPLOYER, AND INFORMATION ABOUT YOUR VEHICLE.

ACCIDENT/INCIDENT INVESTIGATION REPORT

(EXHIBIT 2B)

SECTION I (TO BE COMPLETED BY AFFECTED EMPLOYEE)

EMPLOYEE NAME: JOHN DOE DEPT: SUPPLIES  
DATE OF ACCIDENT/INCIDENT: 07-01-97 TIME: 3:00 AM/PM

LOCATION OF ACCIDENT/INCIDENT: 00 SMITH STREET, EUREKA (CORNER OF SMITH & DUES) (CIRCLE ONE)

HOW DID THE ACCIDENT/INCIDENT OCCUR? WHAT INJURY(IES) RESULTED? (WHAT TASK WAS BEING PERFORMED, WHAT TOOLS AND/OR EQUIPMENT WERE BEING USED, WHAT EVENT OR SEQUENCE OF EVENTS CAUSED THE ACCIDENT/INCIDENT TO HAPPEN?)

JOHN WAS ATTEMPTING TO TURN RIGHT WHEN AN ONCOMING CAR TURNED INTO HIS CITY VEHICLE, CAUSING IT TO HIT A DUMPSTER WHICH KNOCKED OVER A STOP SIGN.

WAS MEDICAL CARE SOUGHT AS A RESULT OF THIS ACCIDENT/INCIDENT? YES X NO

HAS AN EMPLOYEE CLAIM FOR WORKERS' COMPENSATION BENEFITS BEEN FILED AS A RESULT OF THIS ACCIDENT/INCIDENT? YES X NO

John Doe EMPLOYEE SIGNATURE DATE SIGNED 7-1-97

\* \* \* \* \*

SECTION II (TO BE COMPLETED BY DESIGNATED ACCIDENT INVESTIGATOR)

BASED ON YOUR INVESTIGATION OF THE ABOVE ACCIDENT/INCIDENT, DID AN UNSAFE WORKING CONDITION OR UNSAFE ACT CAUSE OR CONTRIBUTE TO THE ACCIDENT/INCIDENT AS DESCRIBED ABOVE? YES X NO. IF YES, WHAT WAS THE CONDITION AND/OR UNSAFE ACT?

IT APPEARS THAT THE ACCIDENT WAS CAUSED BY THE CITIZEN INVOLVED AND COULD NOT HAVE BEEN PREVENTED BY MR. DOE. POLICE REPORT IS FORTHCOMING. WAS THERE PRIOR KNOWLEDGE THAT THIS CONDITION EXISTED? YES X NO. EXPLAIN:

HAD THE EMPLOYEE BEEN PROPERLY TRAINED TO PERFORM THIS DUTY? X YES NO. IF NO, WHY NOT?

WHAT STEPS HAVE BEEN TAKEN TO INSURE THAT AN ACCIDENT/INCIDENT OF THIS TYPE DOES NOT RECUR, AND/OR HOW HAS THE UNSAFE WORKING CONDITION BEEN CORRECTED?

IN THIS CASE, THE SOLE REMEDY APPEARS TO BE TO CONTINUE TRAINING ON DEFENSIVE DRIVING. MR. DOE DID NOT CAUSE NOR CONTRIBUTE TO THIS ACCIDENT.

\* \* \* \* \*

INVESTIGATOR'S SIGNATURE TITLE

DATE INVESTIGATED DATE CORRECTED (IF APPLICABLE)

SUPERVISOR'S SIGNATURE DEPARTMENT HEAD'S SIGNATURE

EXHIBIT #3

**OTHER CLAIMS OF INJURY/PROPERTY DAMAGE FROM A MEMBER OF THE PUBLIC**

PROCEDURE FOR APPROPRIATE NOTIFICATIONS:

IF A MEMBER OF THE PUBLIC MAKES A CLAIM, EITHER VERBALLY OR IN WRITING, THAT THEY HAVE SUSTAINED EITHER (1) A PHYSICAL INJURY ON CITY PROPERTY, AT A CITY EVENT, OR WHILE IN THE CITY'S CUSTODY; OR (2) DAMAGE TO THEIR PROPERTY, **AND** THE FOLLOWING APPLIES, NOTIFICATIONS ARE NECESSARY AS DESCRIBED BELOW:

1. THE PERSON (OR SOMEONE ASSOCIATED WITH THE PERSON) STATES THEY HAVE SOUGHT OR WILL SEEK MEDICAL CARE AS A RESULT OF THEIR CLAIMED INJURY, AND/OR ASKS HOW TO FILE A CLAIM AGAINST THE CITY FOR THE INJURY; OR
2. THE PERSON (OR SOMEONE ASSOCIATED WITH THE PERSON) DISCUSSES POTENTIAL CITY RESPONSIBILITY FOR THE PROPERTY DAMAGE, AND/OR ASKS HOW TO FILE A CLAIM AGAINST THE CITY FOR THE DAMAGE.

IF DURING NORMAL BUSINESS HOURS, CONTACT JEFF DAVIS AT REMIF AT 707-938-2388, EXT. 11.

IF NOT DURING NORMAL BUSINESS HOURS OR IF UNABLE TO REACH REMIF, CONTACT CAL NORTH (JIM CASH) AT 707-443-5302 (OFFICE); 707-269-8870 (PAGER); OR 707-443-9007 (HOME).

**NOTE:** ANY CITY EMPLOYEE CAN MAKE THESE NOTIFICATIONS, WHICH ARE VITAL FOR APPROPRIATE CITY RISK MANAGEMENT.

B. FORMS TO BE COMPLETED (COPY ATTACHED):

- 1: ACCIDENT REPORT FORM

C. PROCEDURE FOR COMPLETING APPROPRIATE FORMS:

1. THE REPORTING EMPLOYEE COMPLETES THE ACCIDENT REPORT FORM (EXHIBIT 3A)
2. THE ACCIDENT REPORT FORM IS FORWARDED TO THE SUPERVISOR/DEPARTMENT HEAD FOR REVIEW AND SIGNATURE. THE COMPLETED FORM IS SENT TO THE CITY ATTORNEY'S OFFICE.

CITY OF EUREKA  
ACCIDENT REPORT FORM

(EXHIBIT 3A)

THIS REPORT MUST BE COMPLETED, DELIVERED, AND FILED IN TRIPLICATE WITH THE CITY ATTORNEY'S OFFICE  
V DEPARTMENT HEAD, IMMEDIATELY AFTER AN ACCIDENT.

ALL ACCIDENTS OR INCIDENTS INVOLVING INJURY TO PERSONS, (FOR INJURY TO CITY EMPLOYEES IN THE LINE  
OF DUTY USE "EMPLOYEE'S CLAIM FOR WORKER'S COMPENSATION BENEFITS" FORM AVAILABLE FROM SUPERVISOR,  
OR PERSONNEL), AND DAMAGE TO PROPERTY OCCURRING ON, OR AS A RESULT OF, THE OPERATION OF CITY OWNED  
PROPERTY OR CITY ACTIVITIES, ARE TO BE REPORTED ON THIS FORM.

TYPE OR PRINT ALL INFORMATION: (IF INADEQUATE SPACE USE REVERSE SIDE).

1. CITY EMPLOYEE MAKING REPORT: NAME JOHN DOE DEPARTMENT SUPPLIES DIVISION N/A  
CITY HALL

2. PLACE OF ACCIDENT: 531 K STREET DATE OF ACCIDENT: 07-01-97 TIME OF ACCIDENT: 1:30 P.M.  
EUREKA

3. VEHICLE ACCIDENT:

A. CITY VEHICLE #, USING DEPT. AND DESCRIPTION  
CITY VEHICLE DAMAGED? YES  NO  DESCRIBE DAMAGE TO CITY VEHICLE \_\_\_\_\_

B. OTHER VEHICLE: MAKE/MODEL \_\_\_\_\_ YEAR \_\_\_\_\_ LICENSE# \_\_\_\_\_  
OTHER VEHICLE DAMAGED? YES  NO  DESCRIBE DAMAGE TO OTHER VEHICLE \_\_\_\_\_

OPERATOR OF OTHER VEHICLE: NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ OPERATOR'S LICENSE # \_\_\_\_\_

4. INJURED: (NAME AND ADDRESS)

A. TRIPPED VAN FELL, 00 HURT LANE, EUREKA, 95503 AGE 43  
B. \_\_\_\_\_ AGE \_\_\_\_\_

5. ON-VEHICULAR ACCIDENTS:

BRIEFLY DESCRIBE PROPERTY DAMAGE, IF ANY: N/A

DESCRIBE INJURIES, IF ANY, AND LIST INJURED ABOVE: MS. FELL TRIPPED ON A LOOSE THREAD  
IN THE CARPET IN THE CITY HALL LOBBY, AND FELL ONTO HER KNEES, HURTING  
THEM BOTH.

6. BRIEFLY DESCRIBE HOW ACCIDENT OCCURRED: MS. FELL WAS IN CITY HALL TO PAY HER  
WATER BILL. AS SHE WALKED INTO CITY HALL FROM THE W<sup>EST</sup> STREET  
ENTRANCE, SHE TRIPPED ON A LOOSE THREAD IN THE CARPET AND FELL TO HER  
KNEES. SHE COMPLAINED OF PAIN IN BOTH KNEES.

7. WITNESSES: (LIST NAME[S] AND ADDRESS[ES])

(A) JOHN DOE, SUPPLIES DEPARTMENT  
(B) \_\_\_\_\_

8. POLICE INVESTIGATION: YES  NO

SIGNATURE OF CITY EMPLOYEE:

John Doe  
SIGNATURE

07-01-97 1:45 P.M.  
DATE AND TIME

NOTED BY DEPARTMENT OR DIVISION HEAD:

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE AND TIME

DO NOT ADMIT LIABILITY. DO NOT DISCUSS THE ACCIDENT OR INCIDENT WITH ANYONE EXCEPT YOUR  
DEPARTMENT OR DIVISION HEAD, AND THE CITY ATTORNEY. SUPPLY THE POLICE WITH YOUR DRIVER'S LICENSE  
NO., THE NAME OF YOUR EMPLOYER, AND INFORMATION ABOUT YOUR VEHICLE.

EXHIBIT #4  
REPORTING "NEAR MISSES"

A. PURPOSE:

THE PURPOSE OF REPORTING "NEAR MISSES" IS TO PREVENT ACTUAL ACCIDENTS FROM OCCURRING BY RECOGNIZING IN ADVANCE CONDITIONS OR ACTS THAT COULD RESULT IN AN ACCIDENT, AND TAKING STEPS TO CORRECT THEM.

B. FORM TO BE COMPLETED (COPY ATTACHED):

1. ACCIDENT/INCIDENT INVESTIGATION REPORT FORM

C. PROCEDURE:

1. WHENEVER AN EMPLOYEE EXPERIENCES OR WITNESSES AN INCIDENT WHICH DID NOT RESULT IN INJURY OR DAMAGE, BUT FOR WHICH THIS POTENTIAL DOES EXIST, THE AFFECTED OR REPORTING EMPLOYEE MUST COMPLETE SECTION I OF THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM (EXHIBIT 4A).
2. THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM IS FORWARDED TO THE DEPARTMENT'S DESIGNATED ACCIDENT INVESTIGATOR. BASED ON THE ABOVE INFORMATION (AND ANY OTHER AVAILABLE), THE ACCIDENT INVESTIGATOR COMPLETES SECTION II OF THE ACCIDENT/INCIDENT INVESTIGATION REPORT FORM, AND REFERS THE FORM TO THE SUPERVISOR/DEPARTMENT HEAD FOR REVIEW AND SIGNATURE. THIS FORM MUST BE SENT TO **PERSONNEL WITHIN ONE WEEK** OF THE OCCURRENCE.

ACCIDENT/INCIDENT INVESTIGATION REPORT

(EXHIBIT 4A)

SECTION I (TO BE COMPLETED BY AFFECTED EMPLOYEE)

YOUR NAME: JOHN DOE DEPT: SUPPLIES  
DATE OF ACCIDENT/INCIDENT: 07-01-97 TIME: 10:30 AM/PM  
LOCATION OF ACCIDENT/INCIDENT: CITY HALL BASEMENT, 531 K STREET (CIRCLE ONE)

HOW DID THE ACCIDENT/INCIDENT OCCUR? WHAT INJURY(IES) RESULTED? (WHAT TASK WAS BEING PERFORMED, WHAT TOOLS AND/OR EQUIPMENT WERE BEING USED, WHAT EVENT OR SEQUENCE OF EVENTS CAUSED THE ACCIDENT/INCIDENT TO HAPPEN?)

JOHN WAS LOOKING FOR A FILE IN A STACK OF FILES ON TOP OF A FILING CABINET WHEN THE ENTIRE STACK FELL OFF THE CABINET.

WAS MEDICAL CARE SOUGHT AS A RESULT OF THIS ACCIDENT/INCIDENT? YES X NO

HAS AN EMPLOYEE CLAIM FOR WORKERS' COMPENSATION BENEFITS BEEN FILED AS A RESULT OF THIS ACCIDENT/INCIDENT? YES X NO

John Doe EMPLOYEE SIGNATURE 07-01-97 DATE SIGNED

\* \* \* \* \*

SECTION II (TO BE COMPLETED BY DESIGNATED ACCIDENT INVESTIGATOR)

BASED ON YOUR INVESTIGATION OF THE ABOVE ACCIDENT/INCIDENT, DID AN UNSAFE WORKING CONDITION OR UNSAFE ACT CAUSE OR CONTRIBUTE TO THE ACCIDENT/INCIDENT AS DESCRIBED ABOVE? X YES NO. IF YES, WHAT WAS THE CONDITION AND/OR UNSAFE ACT?

FILES SHOULD NOT HAVE BEEN STACKED ON TOP OF THE FILING CABINET AND JOHN SHOULD NOT HAVE STOOD UNDER THEM TO RETRIEVE ONE. WAS THERE PRIOR KNOWLEDGE THAT THIS CONDITION EXISTED? X YES NO. EXPLAIN:

IT HAD BEEN NOTED IN A PREVIOUS FACILITY INSPECTION

HAD THE EMPLOYEE BEEN PROPERLY TRAINED TO PERFORM THIS DUTY? X YES NO. IF NO, WHY NOT? IT HAS BEEN DISCUSSED IN PRIOR DEPARTMENT SAFETY MEETINGS

WHAT STEPS HAVE BEEN TAKEN TO INSURE THAT AN ACCIDENT/INCIDENT OF THIS TYPE DOES NOT RECUR, AND/OR HOW HAS THE UNSAFE WORKING CONDITION BEEN CORRECTED?

THE FILES HAVE BEEN REMOVED FROM THE TOP OF THE FILING CABINET AND STAFF HAS BEEN RE-INSTRUCTED IN PROPER METHODS OF FILE STORAGE AND RETRIEVAL.

\* \* \* \* \*

INVESTIGATOR'S SIGNATURE TITLE

DATE INVESTIGATED DATE CORRECTED (IF APPLICABLE)

SUPERVISOR'S SIGNATURE DEPARTMENT HEAD'S SIGNATURE