AUSTIN COUNTY
Accident/Incident Report

Today's Date: _____/_____/_____ **(Appendix A1) APR. 03**

The original Accident /Incident Report must be submitted to Human Resources within 24 hours.

Date of Injury: _____/_____/_____ Date of Incident: _____/_____/_____ No Injury: _____ *(please check)*	Date Reported to Supervisor: _____/_____/_____

Date of Hire: _____/_____/_____ Department Phone Number: _____/_____/_____

Department Head / Elected Official *(print name)*: _____

Name of Employee: _____ Last First Mi. **Job Title:**_____ **Department:** _____	**Work Schedule:** ___ 8am - 5pm M-F ___ 7am - 3:30pm M-F Other _____	**Sex:** ❑ M ❑ F	**Date of Birth:** _____ **Age:** _____
Home Address: _____ _____ City State Zip **Phone #:** _____/_____/_____ **Phone #:** _____/_____/_____ (cell)			**Social Security #:** _____-_____-_____

Employee ID #: **(on your check stub)** _____	**Employee was Working:** ❑ Alone ❑ with Fellow Workers	**Employment Category:** ❑ Full Time ❑ Part Time	**Time and Day of Accident:** ❑ _____A.M. ❑ _____P.M. S M Tu W Th F Sa day of week (circle)

Experience in Occupation at Time of Accident: ❑ Less than 1 month ❑ 1-5 months ❑ 6 months to 1 year ❑ 1-4 years ❑ 5 or more years	**Physician *(Name and Address)*:** _____ _____ _____ Phone: _____/_____/_____	**Hospital / Care Center *(Name and Address)*:** _____ _____ _____ Phone: _____/_____/_____

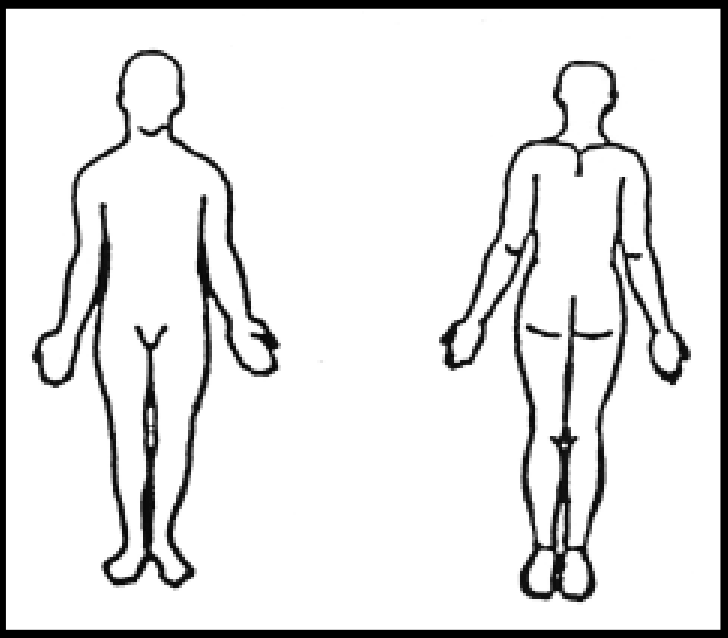
Location of Accident / Incident *(any description or address):*	**Phase of Employee's Workday at Time of Injury / Incident:**
_____ _____ ❑ happened Indoor ❑ happened Outdoor	❑ During break period ❑ Entering or leaving the building ❑ Performing work duties ❑ Working overtime ❑ During lunch period ❑ Other (explain below)

Employee's Supervisor at time of Accident: Witnessed Accident? ❒ yes ❒ no	**Probable Recurrence:** ❒ Frequent ❒ Occasional ❒ Rare	**Loss Severity Potential:** ❒ Major ❒ Serious ❒ Minor

PART of BODY INJURED or AFFECTED **(Please check (√) all that apply to the injury / incident)**

❑ Right Side	❑ Jaw	❑ Abdomen	❑ Throat	❑ Wrist	❑ Ankle	❑ Skin ❑ Finger Nail
❑ Left Side	❑ Ear	❑ Upper Back	❑ Shoulder	❑ Hand	❑ Thigh	❑ Toe Nail
❑ Eye	❑ Neck	❑ Lower Back	❑ Upper Arm	❑ Finger	❑ Foot	❑ No Body Injuries
❑ Nose	❑ Spine	❑ Pelvis	❑ Elbow	❑ Hip	❑ Toe	❑ Other
❑ Mouth	❑ Chest	❑ Head/ Scalp	❑ Forearm	❑ Knee	Describe Other: _____	

Circle Injured Area



Front **Back**

NATURE of INJURY or ILLNESS **(Please fill in the blanks and check (√) all that apply to injury / incident)**

❑ Puncture	❑ Bruise, Contusion	❑ Skin Disorder	❑ Amputation	❑ Muscle Sprain	❑ Cumulative Trauma Disorder	❑ Puncture
❑ Laceration	❑ Dislocation	❑ Burn	❑ Insect/Animal Bite	❑ Muscle Strain	❑ Irritation	
❑ Fracture	❑ Abrasion	❑ Respiratory	❑ Foreign Body	❑ Hernia	❑ Infection	

(Please fill in the blanks and check (√) all that apply to injury / incident)

MEDICAL ATTENTION

First aid was given by:

_____

_____

❒ No First aid required
❒ Drug tested ❒ Alcohol tested

Sent to ❒ Doctor
❒ Hospital / Care Center

NAME OF WITNESSES

(list witnesses and titles)

_____

_____

_____

_____

SEVERITY of injury / incident

❑ First Aid
❑ Medical Treatment
❑ Lost Work Days
❑ Fatality
❑ No Lost Work Days
❑ Other (specify)

(Please complete if there were witnesses to the injury / incident)

WITNESSES STATEMENTS (attach sheet for additional comments)

_____

_____

_____

_____

_____

(Please check (√) all that apply to the injury / incident)

WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED to the ACCIDENT/ INCIDENT?

❑ Close Clearance/Congestion	❑ Floors/Work Surfaces	❑ Inadequate Housekeeping	❑ Defective Tools/Equipment/Vehicle
❑ Hazardous Placement	❑ Inadequate Ventilation	❑ Equipment Failure	❑ Illumination
❑ Inadequate Warning System	❑ Equipment/Workstation Design	❑ Inadequate Guards/Barriers	❑ Inadequate/Improper PPE
		❑ Other:_____	

(Please check (□) all that apply to the injury / incident)

WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS?

❑ Abuse or Misuse	❑ Inadequate Supervision	❑ Inadequate Purchasing	❑ Inadequate Engineering
❑ Inadequate Maintenance	❑ Inadequate Tools / Equipment	❑ Improper Work Surfaces	❑ Wear and Tear
❑ Lack of Knowledge/Training	❑ Improper Motivation	❑ Inadequate Capacity	❑ Lack of Skill
❑ None: _____	❑ Other: _____	❑ Inadequate Surface / Grounds	

(Please check (√) all that apply to the injury / incident)

WHAT ACTION or INACTION CONTRIBUTED to the ACCIDENT / INCIDENT?

❑ Failure to Make Secure	❑ Under the Influence of Drugs/Alcohol	❑ Failure to Warn/Signal	❑ Inadequate/Improper PPE Use
❑ Nullified Safety/Control Devices	❑ Used Defective Equipment	❑ Horseplay/Distractive Action	❑ Operating at Improper Speed
❑ Used Equipment Improperly	❑ Improper Lifting	❑ Operating Procedure Deviation	❑ Running/Rushing/Acting in Haste
❑ Improper Loading	❑ Unauthorized Actions	❑ Used Wrong Tool/Equipment	❑ None
❑ Improper Technique	❑ Improper Position	❑ Servicing/Operating Equipment	❑ Other_____

(Please check (√) all that apply to the injury / incident)

PREVENTIVE MEASURES (What corrective actions have been taken or are planned to prevent a recurrence?)

❑ Improve Enforcement	❑ Improve Clean-Up Procedures	❑ Repair/Replace Equipment	❑ Corrective Counseling
❑ Improve Storage/Arrangement	❑ Rotation of Employee	❑ Eliminate Congestion	❑ Improve/Change Work Method
❑ Identify/Improve PPE	❑ Install/Revise Guards/Devices	❑ Task Analysis to be Completed	❑ Task Analysis/Procedure Revision
❑ Improve Design/Construction	❑ Job Reassignment of Employee	❑ Use Other Materials/Supplies	❑ Improve Illumination
❑ Mandatory Pre-Job Instructions	❑ Improve Ventilation	❑ Re-instruction of Employee	❑ Other_____

Please complete your description as best as you can of the accident / incident)

EMPLOYEE'S DESCRIPTION of ACCIDENT / INCIDENT

(Please have Supervisor complete his/her description of the accident / incident)

SUPERVISOR'S DESCRIPTION of ACCIDENT / INCIDENT (attach sheet for additional comments)

(Supervisor and employee to complete)

SPECIFIC CORRECTIVE ACTIONS or PREVENTIVE MEASURES TAKEN

Corrective Action Taken	Person Responsible	Target Date	Date Completed

I certify that the information provided in this report is true.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action.

I hereby authorize the release of all medical records relating to the injury to my employer and insurance provider.

Employee's Printed Name	Employee's Signature	Date
Supervisor on Duty Print	Supervisor's on Duty Signature	Date
Department Head Print	Department Head's Signature	Date

SCAN AND EMAIL REPORT TO taraw@austincounty.com

AUSTIN COUNTY Contact:

Bryan Haevischer
Treasurer/Human Resources
979-865-5911
www.austincounty.com
bryanh@austincounty.com

Tara Wise
HR Administrative Assistant
979-865-6481
979-865-3783
taraw@austincounty.com

WORKERS' COMPENSATION INSURANCE CONTACT:

Texas Association of Counites Risk Management Pool
JI Companies
10535 Boyer Boulevard, Suite 100
Austin TX 78758
Phone: 512-427-2349
Fax: 512-346-9321
www.jicompanies.com

For ANY accident/incident contact Bellville Urgent Care for mandatory drug/alcohol screening unless medical treatment is necessary. If medical treatment is required proceed to the nearest ER. Note: If the medical facility cannot perform the required screenings contact Bellville Urgent Care. You must take the employee to Bellville Urgent Care to have them tested.

BELLVILLE URGENT CARE

1412 S Front Street
Bellville, TX 77418
Phone: 979-227-4151
Fax: 979-227-4451

Hours of Operations:
Mon-Fri: 9:00 AM to 7:00 PM
Sat-Sun: 9:00 AM to 4:00 PM

For ANY accident/incident contact DSS for mandatory drug/alcohol screening unless medical treatment is necessary. If medical treatment is required proceed to the nearest ER.
Note: If the medical facility cannot perform the required screenings contact DSS.

DSS
DRIVING SAFETY
SERVICES, LLC
Drug & Alcohol Testing Services

110 Merchant St., El Campo, TX 77437
Phone: 979-543-7849 Fax: 979-543-4990
www.dsstpa.com

Dispatch
979-543-7849 - 979-578-1474

Employee Notice of Political Subdivision Workers' Compensation Alliance (Alliance) Program Requirements

Important Contact Information

- Alliance website is www.pswca.org
- Alliance phone number is 1-866-99-PSWCA (1-866-997-7922)
- To contact your adjuster call 1-800-752-6301

Information, Instructions and your Rights and Obligations

Your employer has chosen the Political Subdivision Workers' Compensation Alliance (Alliance) to manage the health care and treatment you may receive if you are injured at work. The Alliance includes a panel of health care providers who are trained in treating work related injuries. They are also trained in getting people back to work safely.

If you are injured at work, tell your supervisor or employer immediately. The enclosed information will help you to seek care for your injury. Also, your employer will help with any questions about how to get treatment. You may also contact Texas Association of Counties via JI Specialty Service for any questions about your care and treatment for a work related injury. The Fund and your employer have formed a team to provide timely health care for injured workers. The goal is to provide quality medical care and return you to work as soon as it is safe to do so.

Injured employees' Rights and Obligations...

What to do if you are injured while on the job...

If you are injured while on the job, tell your employer as soon as possible. A list of Alliance treating doctors may be available from your employer. A complete list is also available online at http://www.pswca.org or, you may contact your adjuster directly at the following address and/or toll-free telephone number:

JI Specialty Services
P.O. Box 160120 Austin, TX 78716
800-752-6301

In case of an emergency…

If you are hurt at work and it is a life-threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours, you should go to the nearest care facility.

Emergency care does not need to be approved in advance. "Medical emergency" is defined in Texas laws. It is a medical condition that comes up suddenly. There are acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

EMPLOYEE COPY

Non-emergency care…

Once you have selected your treating doctor, you will need to notify your adjuster of your selection by calling and advising them or you can complete the "Treating Doctor Selection Form" pool JI2 form and submit to your adjuster.

Complaints

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of the operation. This includes a complaint about the Alliance or an Alliance doctor. It may also be a general complaint about the PSWCA Direct Contracting Program.

A complainant can notify the PSWCA Direct Contracting Program Grievance Coordinator of a complaint by phone or in writing via mail or fax. Complaints should be forwarded to:

PSWCA Direct Contracting Program
Attention: Grievance Coordinator
P.O. Box 763 Austin, TX 78767
1-866-99-PSWCA (1-866-997-7922)
E-mail: customerservice@pswca.org

EMPLOYEE COPY

Employee Acknowledgment of PSWCA Direct Contracting Program

I have received information that informs me of my employer's relationship with the Alliance and how to get health care if I suffer a work related injury/illness.

If I am injured on the job, I understand that:

1. I must choose a treating doctor from the list of doctors provided by my employer or obtain the list myself which is located at **www.pswca.org**
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. JI Specialty Services for Texas Assn of Counties will pay the treating doctor and other referral providers.
4. I may be required to pay for health care received from a provider if that provider is not on the approved list.
5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
6. Additional information regarding the PSWCA is available on my pool's website at www.county.org

_____ _____
Signature Date

_____
Printed Name

I live at: _____
Street Address

_____
City State Zip Code

Name of Employer: _____

Call 800-752-6301if you need assistance locating a treating provider.

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: ____ /____ /____)

PLEASE RETURN THIS FORM TO YOUR EMPLOYER
DO NOT RETURN THIS FORM TO JI SPECIALTY SERVICE UNLESS REQUESTED

Important Contact Information

- Alliance website is www.pswca.org
- Alliance phone number is 1-866-99-PSWCA (1-866-997-7922)

To contact JI Specialty Service call 800-752-6301

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_____ _____
Signature Date

_____
Printed Name

I live at: _____
Street Address

_____
City State Zip Code

Name of Employer: _____

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HR COPY