Town of Fair Haven THE SLATE CENTER OF THE NATION • CHARTERED OCTOBER 27, 1779

FAX: 265-3176 • MUNICIPAL BUILDING • NORTH PARK PLACE • FAIR HAVEN, VERMONT 05743 • TEL. (802) 265-3010

Incident Reporting, Medical Treatment & Accident Investigation Policy

This policy establishes procedures for the reporting of all work-related incidents **when an injury occurs that is treated via first aid or actual medical treatment in the form of a visit to a medical provider**. Incidents with no medical treatment or first aid do not fall under this policy.

This policy also establishes a designated medical provider for all Workers' Compensation injuries, in compliance with Rule 12 of the Vermont Workers' Compensation Rules.

Lastly, the policy outlines specific procedures to be used in recording and following-up on work-related injuries. The *Fair Haven, VT Employee Incident/Injury Review Report* form must be used to document information regarding employee injuries for filing Workers' Compensation claims and to identify loss prevention opportunities. It is incorporated into this policy by reference.

Nothing in this policy amends or changes existing contractual rights, obligations or language. Rather, it intends to enhance Fair Haven's ability to prevent injuries, manage workers' compensation claims in accordance with regulatory requirements, and to obtain the best medical outcomes for employees who experience a work-related injury.

I. Reporting Requirement

a. All injuries that occur as outlined above shall be reported to the shift supervisor immediately or as soon as practical (but no later than the end of the shift).
b. These initial injury reports may be provided in writing, in person, via phone, 2-way radio or other appropriate means.
c. The employee shall participate and cooperate with the department head/supervisor in the investigation of the accident (see section III).
d. In cases where an employee voluntarily delays medical treatment or first aid for a work-related injury until some time after the injury (including those deciding to seek treatment hours or days later), that employee shall promptly notify their immediate supervisor that treatment is desired and shall obtain treatment as outlined in section II below.
e. If the employee has been kept out of work for medical reasons due to the work-related injury, they shall report their expected absence as required by the Town's Transitional Return to Work Program Policy and provide written documentation from the treating medical provider indicating that the individual has been directed to remain out of work.

II. Medical Treatment

a. When an injury warrants treatment **that is more than self-administered, basic first aid**, employees shall obtain evaluation and treatment from the Town's designated medical provider – **Rutland Regional Medical Center Occupational Health (802-747-1753)**. The injured worker or supervisor should call the provider in advance of the impending visit.
b. Where emergency medical treatment is required 9-1-1 shall be called and the injured employee taken to the appropriate emergency medical facility.

c. When non-emergency treatment is required outside of the designated medical provider's office hours, employees shall use one of the **Community Health Centers of the Rutland Region or a local emergency department**.
d. Where an employee desires to see an alternate medical provider, they may do so after seeing the designated medical provider listed in this policy. A *Form 8* (VT Workers' Compensation Div.) must be used.
e. In all cases where medical treatment is obtained from a healthcare provider, employees shall use a work capabilities form (for the medical provider to complete) to document the current work abilities and restrictions, if any. The VT Department of Labor's *Form 20* or its equivalent is an acceptable form to be used by the medical provider. The Town (e.g., supervisor or Town Manager's Office) will provide a copy of an appropriate form upon request.

III. Incident/Injury Review Procedures

a. Within 24 hours of receiving notice of a work-related injury, the supervisor shall complete a *Fair Haven, VT Employee Incident/Injury Review Report* form with the injured employee.
b. This form gathers facts about the incident, its cause, witnesses, temporal information, and other information necessary to file the claim and, ultimately, to identify ways to prevent similar future injuries.
c. Care shall be taken to avoid discipline-related issues during the incident review discussion between the supervisor and the injured employee. Any warnings or other disciplinary actions shall take place separately from the incident review process.
d. Both the supervisor and the injured employee shall sign the form attesting to its accuracy.
e. Also, the supervisor shall complete the on-line *VLCT First Report of Injury* form with the injured employee within 72 hours upon learning of the injury. If extenuating medical circumstances prevent the employee from participating, the supervisor shall complete form as soon as possible, using any and all information and assistance available.
f. Printed copies of the *Fair Haven, VT Employee Incident/Injury Review Report* and the *VLCT First Report of Injury* forms shall be provided to the Town Manager.
g. All completed forms shall be retained and reviewed by the Town Manager (and the Town Safety Committee, as applicable) for completeness and monitoring of corrective actions.

Adopted this 5th day of January, 2015 by the Fair Haven Selectboard.

Christopher Cole, Chair

Robert Richards

Jeffrey Sheldon, Clerk

David Ward

Roderic Holzworth, II

Fair Haven, VT Employee Incident/Injury Review Report

This form is used to document information required by VOSHA 1904 (Recording & Reporting of Occupational Illnesses and Injuries) and Vermont Workers' Compensation Rule 3 and its subparts. The form must be completed as soon as possible, but in no case later than 24 hours after the injury occurs. As appropriate, this information is used by the city to file a workers' compensation claim.

Indicate Expected Incident Type 1st Aid☐ Med Only☐ Med with Lost Time☐	Department:		Report Completed Date
Exact Location of Incident:	Date of Incident:	Time of Incident: a.m./p.m.	Date Reported:

Work-Related Injury or Illness	**Tools and Safety Equipment**	**Other Information**
Injured Worker's Name:	Was a Machine or Tool Involved? Yes ☐ No ☐	List any witnesses below. Interview each witness individually. Signed witness statements should be maintained separately. 1. 2. 3.
Part of Body: RT/LT	If yes, was machine or tool defective? Yes ☐ No ☐	
Describe Injury/Illness:	Safety Equip/PPE Required? Yes☐ No☐ If Yes, was it used: Yes☐ No☐	
Presently, is any loss of work time expected? Yes ☐ No ☐	Was there anything the injured worker could have done to prevent the injury?	**Indicate Shift Start Time on Date of Injury:** _____
Job Title:		

Was *First Aid* Provided? Yes ☐ No ☐ If YES, by whom:

Was *Medical Treatment* provided by a healthcare provider? Yes☐ No☐
Check ☐ if from ***Rutland Regional Medical Center Occupational Health***. Provide name of medical provider IF other medical provider was used:

Describe details leading up to and including the accident/injury or manifestation of symptoms:

What conditions, circumstances or factors contributed to this incident (i.e. tools, equipment, PPE, policies, object, training, hazards, employee action/inaction, etc.)? Be thorough and descriptive!

Correction Suggestions (Note what could be done to prevent this from happening again-*being more careful is not an option*)

Who is responsible for reviewing/implementing corrective actions noted above?

Signature of Reviewing Supervisor:		Date:	
Employee Signature:		Date:	

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TO: All Employees

FROM: Herbert A. Durfee, III, Town Manager

DATE: January 6, 2015

SUBJECT: Workers Compensation Designated Physician

This memo serves to inform you that the Selectboard adopted policy regarding a Designated Physician for Workers Compensation following a work related accident. Workers Compensation law, Rule 12 (copy available at the Town Offices or on-line at VT Dept of Labor) gives employers the right to refer an employee to a particular provider for his/her first medical visit after an injury. In case of an emergency, it may not be practical to use a network provider. However, in non-emergency situations, the employer may then request follow up treatment with a network provider. After the employee's first Designated Physician visit, he/she may:

Select their own physician if they meet the following conditions:

1. The employee must notify the employer in writing setting forth the employee's reasons for dissatisfaction with the physician designated by the employer;
2. The employee's written notice must identify the physician or medical provider from whom the employee intends to seek treatment.

Please note that Rule 12 states that an employer can refuse to reimburse for medical charges, if these guidelines are not followed, as well as those listed under Rule 12, Section (b) regarding maximum allowable medical expenses.

As such, the Selectboard has selected ***Rutland Regional Medical Center Occupational Therapy*** (802-747-1753) in Rutland as their provider.

Please speak with your supervisor or Jenny Bertrum, if you have questions regarding the procedure outlined above.

On behalf of the Selectboard, I ask that you sign this memo and return it to your supervisor or Jenny Bertrum, this will confirm that you have received and understand the adopted Designated Physician for Workers Compensation procedure.

Date:_____ Signature:_____