# Town Of Beaufort
# Injury/Accident Reporting
# Standard Operating Procedures (SOP's)

## Purpose:

To provide a standard system of reporting a work related injury and/or accident.

## Scope:

All personnel

## Policy:

The following procedures will be followed by all Town of Beaufort employees for a work-related injury and/or accident.

1. In the event of a life threatening work related injury/accident, please contact 911 immediately for transport to the hospital. Notify the employee's Supervisor immediately.
2. If an employee sustains a non-life threatening work-related injury/accident, they must notify their Supervisor immediately.
3. If treatment is required, the employee will be transported by a Supervisor (or designee) for treatment to:

   Beachcare Urgent Care
   5059 Highway 70, Morehead City, NC
   Phone number 252-808-3696

4. If Beachcare is closed, the employee will need to be transported for treatment to the hospital.
5. A post-accident test for drugs and/or alcohol shall be administered within two (2) hours following a work related accident/injury. Employee may not be allowed to return to work until the results of the drug/alcohol tests have been reviewed by the proper Town staff. The post accident drug and/or alcohol test can be obtained at Beachcare Urgent Care.
6. The following Worker's Compensation Insurance Information will be provided to the medical office:

   NCIRMA – WC
   PO Box 1310
   Raleigh, NC 27602

   Phone number: 888-581-1083
   Carrier Code: 999-108

7. The Human Resource Office must be notified within 24 hours (or Monday morning if injury occurs over the weekend) of the work-related injury/accident.
8. For all injuries, the On the Job Injury Report must be completed by the employee and their Supervisor, and turned into Human Resource Office within 48 hours.
9. The injured employee will receive a completed North Carolina Industrial Commission (NCIC) Form 19, together with a blank NCIC Form 18.

# Town Of Beaufort
# On the Job Injury/Accident Report
***(To be submitted by Supervisor)***

## EMPLOYEE/DEPARTMENT INFORMATION

Employee Name: _____ SSN Last 4 digits: _____

Job Title: _____ Department: _____

Supervisors Name: _____ Current Date _____

## INCIDENT INFORMATION

Date Incident Occurred: _____ Time of incident: _____ Date Supervisor was notified: _____

Time Employee arrived at Work: _____

Did the employee: ☐ See a doctor ☐ Receive First Aid ☐ Have a Near Miss ☐ Refuse Medical Treatment

**Where did the incident occur?** (Location name, address, brief description. Examples: "Fire Station - 900 Cedar Street; kitchen" or "Piggly Wiggly Parking lot on Live Oak Street, southwest corner")

**What was the employee doing just before the incident occurred?** Describe the activity and any tools being used. Examples: "carrying a recycling bin during routine pick up" or "installing a metal parking sign"

**What happened?** Tell us how the injury occurred. Examples: "Employee slipped and fell 3 feet into a ditch." or "Car pulled out in front of vehicle causing vehicle to swerve and run off the road."

**What was the injury or illness?** Tell us what part of the body is affected and how. Be as specific as possible. Examples: "2nd degree burn on left hand" or "sprained right ankle"

**What object or substance directly harmed the employee**? Examples: "concrete floor" or "hacksaw" or "steering wheel"

**When did the employee return to work?** Date: _____ Time: _____

## PHYSICIAN INFORMATION (IF APPLICABLE)

Physician Name: _____ Facility Address:: _____

Facility Telephone: _____ _____

ER Visit:: ☐ Yes ☐ No Overnight Visit: ☐ Yes ☐ No

## VERIFICATION

Employee Signature: _____ Date:: _____

Supervisor Signature: _____ Date:: _____

(If submitted electronically, typing your name here serves as your signature.)