

Injury Reporting Procedure

If you are the employee injured:

1. Notify your Captain of the injury.
2. Seek immediate appropriate medical attention, if required. If emergent medical care is required use any appropriate medical facility. If non-emergent medical care is required please use any of the First Med system medical clinics or hospitals.
3. If no medical attention is required **and** no loss of time from work will occur, complete Unified Fire Authority First Aid Only Form. Skip to step 5.
4. If the injury requires medical attention or loss of time from work complete State of Utah form 122, the Workers Compensation Employer's First Report of Injury or Illness.
5. Forward completed form(s) to your Captain.

All fields on the above mentioned forms are required and must be filled out to the fullest extend possible. If a field is not applicable, mark that field with an "N/A".

If you are the Captain of an injured employee:

1. Insure that all appropriate medical attention is received, if appropriate. If emergent medical care is required use any appropriate medical facility. If non-emergent medical care is required please use any of the First Med system medical clinics or hospitals.
2. Notify your Battalion Chief of the injury.
3. If no medical attention is required **and** not loss of time from work will occur, insure that the employee has completed Unified Fire Authority First Aid Only Form is completed. Skip to step 5.
4. If the injury requires medical attention or will result in loss of time from work, insure that the employee has completed the State of Utah form 122, the Workers Compensation Employer's First Report of Injury or Illness.
5. Complete the U.F.A.'s Supervisor's Report of Injury or Illness form.
6. Insure that the receiving medical facility is aware of the situation.
7. The incident must be logged in the station log. The information must reflect who was involved, what the nature of the incident was (including the case number), the circumstances leading to the injury, the details of the injury itself, immediate actions taken to remediate the situation, and the final disposition of the incident.
8. In the event that the injured person is incapacitated, it is your responsibility to ensure the proper forms are completed.
9. Forward copies of the completed forms to your Battalion Chief.

All fields on the above mentioned forms are required and must be filled out to the fullest extend possible. If a field is not applicable, mark that field with an "N/A".

Copies of all completed forms are to be kept in a secure location at the station.

If you are the Battalion Chief of an exposed person:

1. Insure that all appropriate medical attention is received, if appropriate. If emergent medical care is required use any appropriate medical facility. If non-emergent medical care is required please use any of the First Med system medical clinics or hospitals.
2. Notify the Safety Officer of the injury.
3. If no medical attention is required **and** not loss of time from work will occur, insure that the employee's Captain has completed Unified Fire Authority First Aid Only Form is completed. Skip to step 5.
4. If the injury requires medical attention or will result in loss of time from work, insure that the employee's Captain has completed the State of Utah form 122, the Workers Compensation Employer's First Report of Injury or Illness, completed to the fullest extent possible.
5. Review the U.F.A.'s Supervisor's Report of Injury or Illness form that has been completed by the Captain. Additional comments may be added, however insure that your comments are kept separate from the Captain's and insure it is clearly annotation whose comments are whose.
6. Insure that the employee's Captain has insured the received medical facility is aware of the situation.
7. In he event that the employee's Captain is incapacitated, it is your responsibility to ensure that the proper forms and notifications are completed.
8. Insure that copies of the proper completed forms are forwarded to the Safety Officer.

All fields on the above mentioned forms are required and must be filled out to the fullest extend possible. If a field is not applicable, mark that field with an "N/A".

Copies of all completed forms are to be kept at a secure location at the Battalion Chief's office.

If there are any questions please contact the Safety Officer as soon as possible.



FIRST AID REPORT ONLY
UNIFIED FIRE AUTHORITY

EMPLOYEE NAME _____ SSN _____

ADDRESS _____ CITY, STATE _____

HOME PHONE _____ ZIP _____

DATE OF BIRTH _____ WAGES, ANNUALLY _____

OR HOURLY _____

GENDER ___ M ___ F

DATE OF HIRE _____ DATE/TIME OF INJURY _____

SUPERVISOR'S NAME/PHONE # _____

DATE/TIME SUPERVISOR INFORMED _____

ST# & PLT OR DIV. _____ JOB TITLE _____

CAUSE _____ LOCATION OF INCIDENT _____

WITNESS NAME & PHONE # _____

DESCRIPTION OF ACCIDENT, INJURY OR NEAR ACCIDENT: _____

INITIAL TREATMENT: _____

CAN PROBLEM BE CORRECTED? ___ YES ___ NO

WERE SAFEGUARDS & SAFETY EQUIPMENT PROVIDED? ___ YES ___ NO

WERE THEY USED? ___ YES ___ NO

SAFETY COMMITTEE REVIEW DATE _____

COMMITTEE'S RECOMMENDATION _____

Fax Completed Form To:
Safety Officer
743-7211

FORM 122

For your protection Utah Law requires notice that worker's compensation fraud is a crime. Please see back of this form for the full fraud statement.

**WORKER'S COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
STATE OF UTAH - THE LABOR COMMISSION - DIVISION OF INDUSTRIAL ACCIDENTS
160 E 300 S, P.O. BOX 146610 SALT LAKE CITY, UTAH 84114-6610**

GENERAL	EMPLOYER (Name & Address incl. Zip) Unified Fire Authority 3380 South 900 West Salt Lake City, UT 84119		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	INDUSTRY CODE		EMPLOYER FEIN 75-3134967	JURISDICTION	JURISDICTION CLAIM NUMBER
	CARRIER/CLAIMS ADMINISTRATOR		INSURED REPORT NUMBER		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
	CARRIER (NAME, ADDRESS, & PHONE#)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)	
CARRIER	CARRIER FEIN		POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN	
	AGENT NAME AND CODE NUMBER		CHECK IF APPROPRIATE <input type="checkbox"/> SELF-INSURANCE		PHONE # (801) 743-7200
	EMPLOYEE/WAGE		POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)
	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED
EMPLOYEE	ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	
	PHONE		# OF DEPENDENTS	OCCUPATION / JOB TITLE	
	RATE PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER		# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY / ILLNESS CODE		DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO
OCCURRENCE	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE
	CONTACT NAME/PHONE NUMBER		TYPE OF INJURY / ILLNESS		PART OF BODY AFFECTED
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		CAUSE OF INJURY CODE
	HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL				
	DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO
TREATMENT	PHYSICIAN/HEALTH CARE PROVIDER (NAMES & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
	OTHER				
OTHER	WITNESSES (NAME & PHONE #)				
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER

SUPERVISOR'S REPORT OF INJURY OR ILLNESS

ALL ITEMS MUST BE ANSWERED FULLY

EMPLOYEE

WARNING: "WORKERS' COMPENSATION INSURANCE FRAUD IS A CRIME PUNISHABLE BY LAW."

Location (print) _____ State _____ Department _____ Phone Number _____
 Employee Name _____ Date of Birth _____ Employee # _____
 Address _____ City _____ State _____ Zip _____
 Social Security # _____ Married: Yes No Sex: Male Female Age _____
 Job Title _____ Length of Service with Company _____ Years
 Hourly Wage Rate \$ _____ Job Being Performed at Time of Injury _____
 Description of Incident: _____

Release of Medical Information

I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and to LWP Claims Solutions, Inc., all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the Company will use the information to verify my disability and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care provider, hospitals and clinics, insurance companies and workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photocopy of this authorization will be as valid as the original.

Employee Signature _____ Date _____

INCIDENT DETAILS

Date of Incident _____ Time of Incident _____ AM PM Date Reported _____
 Shift: Graveyard Days Afternoon Other Was Employee on Overtime? Yes No Time Shift Commenced _____
 Incident Location (specific area) _____ On employer premises? Yes No
 Witness(es) to Incident _____
 Did Employee lose time due to the injury? Yes No First Aid Given? Yes No
 Date worker left work _____ Time worker left work _____ Date worker returned to work _____
 Complete if Applicable: Medical Facility _____ Doctor _____

(if Medical Attention is sought, complete State Form)

Follow up appointment scheduled? Yes No
 Was time off authorized by the physician? Yes No If yes, how many days? _____

Treatment given Prescription Irrigation Sutures Tetanus Shot
 Brace Cast Removal of Foreign Object None
 Ace Bandage Other

PART OF BODY INJURED – MARK ALL THAT APPLY

- | | | | | |
|------------------------------------|--|--|--------------------------------------|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Arm R - L | <input type="checkbox"/> Trunk | <input type="checkbox"/> Hip R - L | <input type="checkbox"/> Foot R - L |
| <input type="checkbox"/> Face | <input type="checkbox"/> Elbow R - L | <input type="checkbox"/> Shoulder R - L | <input type="checkbox"/> Thigh R - L | <input type="checkbox"/> Toe - Identify |
| <input type="checkbox"/> Eye R - L | <input type="checkbox"/> Forearm R - L | <input type="checkbox"/> Chest | <input type="checkbox"/> Knee R - L | <input type="checkbox"/> Ribs R - L |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Hand R - L | <input type="checkbox"/> Back: Lower-Upper | <input type="checkbox"/> Leg R - L | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Finger - Identify | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Ankle R - L | <input type="checkbox"/> Other
(describe) |

SUPERVISOR

SUPERVISOR

NATURE OF INJURY – MARK ALL THAT APPLY

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Puncture | <input type="checkbox"/> Exposure-Chemical | <input type="checkbox"/> Inhalation | <input type="checkbox"/> Burn-Heat-Chemical |
| <input type="checkbox"/> Bruise-Crushed | <input type="checkbox"/> Fracture-Dislocation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Fatality | <input type="checkbox"/> Other (<i>describe</i>) |
| <input type="checkbox"/> Laceration Cut | <input type="checkbox"/> Poisoning-Systemic | <input type="checkbox"/> Sprain | <input type="checkbox"/> Exposure-Heat/Cold | |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Strain | <input type="checkbox"/> Foreign Object | |

INVESTIGATION

Date of Investigation _____ Person(s) Making Investigation _____
Employee's Supervisor (print name) _____ Supervisor's Phone # _____
Who was immediately in charge at the time of injury _____
Was Employee Task Trained? Yes No If Yes, explain _____
Were Safety Codes/Rules Violated? Yes No If Yes, explain _____
Equipment Involved: Type _____ Model No. _____ Manufacturer _____

CAUSE OF INJURY – MARK ALL THAT APPLY

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Body Motions | <input type="checkbox"/> Hot/Cold Temperatures | <input type="checkbox"/> Flame/Fire/Smoke | <input type="checkbox"/> Ladders | <input type="checkbox"/> Slip/Trip/Fall |
| <input type="checkbox"/> Bldg/Structures | <input type="checkbox"/> Conveyers | <input type="checkbox"/> Furniture/Fixtures | <input type="checkbox"/> Machines-Misc. | <input type="checkbox"/> Flying Objects |
| <input type="checkbox"/> Chemicals | <input type="checkbox"/> Electrical – HV | <input type="checkbox"/> Hand Tools-Non Power | <input type="checkbox"/> Noise | <input type="checkbox"/> Flash |
| <input type="checkbox"/> Infectious Agents | <input type="checkbox"/> Electrical – LV | <input type="checkbox"/> Hand Tools – Power | <input type="checkbox"/> Particles | <input type="checkbox"/> Other |
| <input type="checkbox"/> Vehicles | <input type="checkbox"/> Falling Objects | <input type="checkbox"/> Hoisting Apparatus | <input type="checkbox"/> Sharp Objects | |

CAUSE OF INCIDENT – MARK AND EXPLAIN ALL THAT APPLY

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Equipment Failure | <input type="checkbox"/> Improper Material Handling | <input type="checkbox"/> Excessive Speed | <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Lack of Attention | <input type="checkbox"/> Wet Slippery Uneven Surface | <input type="checkbox"/> Procedure Failure | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other (explain) |

ANALYSIS

Description of Incident: _____

STEPS TAKEN TO PREVENT SIMILAR OCCURRENCE – MARK AND EXPLAIN ALL THAT APPLY

- | | |
|---|---|
| <input type="checkbox"/> Reinstruction of Employee Involved | <input type="checkbox"/> Formal Disciplinary Action |
| <input type="checkbox"/> Reminder Instruction of all Employees | <input type="checkbox"/> Installation of Guard Device |
| <input type="checkbox"/> Personal Protective Equipment Required | <input type="checkbox"/> Counseling of Employee |

Comments: _____

Supervisor Signature _____ Date _____