Western Carolina University | Safety and Risk Management

# OCCUPATIONAL INJURY REPORTING

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# Scope

The North Carolina Worker's Compensation Act (NC General Statues, Chapter 97) covers all University employees, including full-time faculty, staff (EPA and SPA), senior administrative officers, part-time employees, temporary employees, and student employees.

Workers' Compensation benefits are available to any employee who suffers an accidental injury or occupational disease arising out of, and during his or her employment, according to the provisions of the North Carolina Workers' Compensation Act. The full cost of medical treatment is covered by Workers' Compensation if the injury/illness is compensable under the Workers' Compensation Act.

The North Carolina Industrial Commission (NCIC) and the North Carolina Occupational Safety and Health Administration (OSHNC) are both responsible for ensuring that employers in North Carolina administer the provisions of the Worker's Compensation Act. The University strives to maintain reporting guidelines established by the NCIC and OSHNC, prevent injury reoccurrence, and maintain a workplace that is free of recognized hazards for the benefit of all university employees.

# Procedures

**Incident Response & Medical Treatment**

The following procedures should be followed immediately after an incident occurs:

1. All employees should seek medical treatment immediately after an injury occurs. Employees are advised not to treat with their own physicians since the insurance company, Corvel, will not cover treatment at facilities not approved by them.

2. Life-threatening injuries: Call 911 if the injury is serious or life-threatening. The following examples of serious or life threatening symptoms: loss of consciousness, seizure, bleeding that cannot be immediately controlled, chest pain or pressure, difficulty breathing, confusion, inability to talk, walk or raise both arms. Note: During medical emergencies, employees may request that EMS not be called. The employer has a legal and moral obligation to call EMS if a life-threatening situation is suspected. Do not delay care; do not argue with the victim; call 911.

3. If the injury is an emergency and the response involves the transport of an employee to the hospital, the supervisor or designee should go to the hospital to provide support.

4. Supervisors should ensure the scene is safe for employees and emergency responders or remove victim in extreme situations when the scene is dangerous to life and health.

5. Supervisors should secure the scene:
    - Isolate the scene with rope, tape, guards, etc. (if needed)
    - Provide a hard copy of the NC Employee Incident Report (Appendix A) for the employee to complete. This must be forwarded to the Safety & Risk Management Office within 24 hours from the time of the injury.
    - Do whatever it takes to prevent a reoccurrence while preserving all evidence.

6. Non-life threatening injuries: If the injury is not an emergency but requires additional medical care, employees should go to one of the three approved health care facilities:

   **Student Health Services**
   Bird Health Building
   (828)227-7640
   Hours: Monday-Friday 8AM-5PM
   Saturday-Sunday CLOSED

   **Harris Regional Urgent Care**
   176 Wal-Mart Plaza (Next to Walmart)
   Sylva, NC 28779
   Phone (828)631-9462
   Hours: Open 7 days a week 8AM-6:30PM

   **Harris Regional Hospital ER**
   68 Hospital Road
   Sylva, NC 28779
   Phone (828)586-7000
   Hours: Open 24/7

   If the employee is on official state business and is injured outside the Cullowhee/Sylva area, they should seek treatment at the closest ER or Urgent Care Center.

   For injured employees, additional health care needed by a specialist will be coordinated between the Safety & Risk Management Office, the initial treating physician, and Corvel Corporation (third party administrator for Worker's Compensation Claims).

7. Supervisors and employees shall not release information to the news media. Employees must instruct inquiring media to contact WCU's Office of Communications and Public Relations Office at (828)227-7327, 400 HFR Building.

# Responsibilities

**Employee**

Responsibility for claiming compensation falls on the injured employee. Employees are responsible for the following after a work-related injury occurs:

- Injured employees should notify their supervisor immediately of any work-related injuries.
- All injuries must be reported to the Safety & Risk Management office within 24 hours.
- Seek medical treatment at one of the three designated treatment facilities listed above.
- Employees should not see their personal doctors for work related injuries.
- Employees are expected to fully cooperate with their supervisor during the investigation process (See section IV Incident Investigation)

- Employee must provide their supervisor and Safety & Risk Management office with all work notes they receive from the authorized treating physician and let their supervisor know of any changes in their work status.
- Complete the North Carolina Employee Incident Report Form (Appendix A) and Employee Use of Leave Options Form (Appendix B) if you miss time from work. Your supervisor should review the forms and return them to the Safety & Risk Management Office within 24 hours.
- Employee is expected to follow all doctor's orders, accept all medical treatment, and attend all scheduled appointments.

**Supervisor**

The supervisor is responsible for notifying the Safety & Risk Management Office of any work-related injury within 24 hours. The supervisor should be prepared to provide information to the Safety & Risk Management Office regarding the time, location, and nature of the accident. Supervisors are also responsible for the following after a work-related injury is reported to them:

- Direct injured employee to one of the three designated medical treatment facilities immediately after the injury occurs or as soon as you are notified.
- If the injury is an emergency and the response involves the transport of an employee to the hospital, the supervisor or designee should go to the hospital to provide support.
- Supervisors should ensure the scene is safe for employees and emergency responders or remove victim in extreme situations when the scene is dangerous to life and health.
- Supervisors should secure the scene:

    1. Isolate the scene with rope, tape, guards, etc. (if needed)
    2. Provide a hard copy of the NC Employee Incident Report (Appendix A) for the employee to complete. This must be forwarded to the Safety & Risk Management Office within 24 hours of the incident.
    3. Do whatever it takes to prevent a reoccurrence while preserving all evidence.

- Serious injuries resulting in fatality, amputation, loss of eye(s), or admission to hospital must be immediately reported to the Safety & Risk Management Office at 828-227-7443 (Appendix E)
- Supervisors should work with the employee to investigate the incident (See section Incident Investigation).
- Ensure the employee completes the North Carolina Employee Incident Report Form (Appendix A) and Employee Use of Leave Options Form (Appendix B) if they are missing time from work. Ensure the forms are returned to the Safety & Risk Management office within 24 hours after the incident.
- If there are witnesses to the incident, have NC Witness Statement Forms completed (Appendix D). Complete the Supervisor Incident Investigation Report (Appendix C) and return forms back to the Safety & Risk Management Office within 24 hours after the incident.
- Ensure all work notes you receive are forwarded to the Safety & Risk Management Office.
- Work to accommodate any modified duty that is ordered by the treating physician and notify Safety & Risk Management of any changes in employee's work status.

- Keep in contact with injured workers who are missing time from work.

## Incident Investigation

All incidents and "near misses" that occur on state property, leased properties, and in the course of business on or off-site must be reported by the employee and investigated by the supervisor using a team process and root cause investigation. To clearly identify the unsafe circumstances surrounding the occurrence of the incident, a cause and effect needs to be identified. The cause is the why a particular incident happened (i.e. oil on the floor). The effect is the result of what occurred (i.e. the employee slipped and bruised leg). When looking for the cause, several items should be investigated such as processes (i.e. lack of scheduled maintenance for equipment, changes to procedure), personnel (i.e. lack of training), machine/equipment (i.e. faulty equipment that leaks), materials (i.e. no tools), and environment (i.e. poor worksite cleanliness). Once the cause(s) are identified, then corrective action is to be implemented to mitigate future occurrence. In some cases, employee failure to follow proper safety procedures may be identified and should not be excluded.

**Supervisor Responsibility in Incident Investigation**

The Supervisor is responsible for investigating any workplace incident that occurs in their department. Employees are required to cooperate in the investigation and complete all necessary paperwork. The incident investigation should occur as soon as the injury is reported to the supervisor. It is critical to evaluate the scene of the accident before changes can occur and obtain witness statements before memory alters, etc.

After conducting the incident investigation, the NC Supervisor Incident Investigation Report (Appendix C) is to be completed and list any details that may correct the problem and/or to increase health and safety awareness. Supervisors are encouraged to include supplemental information such as pictures/diagrams of the accident scene, and other agency reports such as police or fire. All reports and supplemental documents should be immediately sent to the Safety & Risk Management Office for review.

**Correction of Hazards**

Any deficiencies identified during the supervisor incident investigation should be immediately reported to the Safety & Risk Management Office to be corrected.

The Safety & Risk Management department will work with the department to correct any deficiencies that are found. If any deficiencies identified have the potential for serious injury/illness, then Safety & Risk Management has authorization to stop all work until the hazard has been corrected.

## Training

All employees and new hires will receive training on the WCU Occupational Injury Reporting program. Employees and supervisors will receive appropriate refresher training at regularly scheduled intervals as determined by the Safety & Risk Management Office.

The minimum training for all employees will include the following elements:

- An explanation of the WCU Occupational Injury Reporting program and roles
- An emphasis on the importance and method of prompt reporting of incidents and near misses
- Review of the Employee Incident Form, the Supervisor Investigation Form and the NC Witness Statement Form

## Record Retention

The State of North Carolina will maintain information related to incident investigations for 30 years past the employee separation date. All incident investigation records will be kept by the Program Administrator. "Near miss" investigation reports will be maintained for five years.

# Appendix A: Employee Incident Form

## NORTH CAROLINA EMPLOYEE INCIDENT REPORT

**Instructions: Employee must complete report. If more room is needed, continue in a Word document and attach it to this submission.**

Employees are required to complete this form for all incidents and near hits. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

Supervisor Review: If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report.

My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Check ☐ Not applicable (employee completed form) or sign below if you assisted with the completion of this form.

Supervisor Name: Signature:

| Employee Information | | | Date/Location Information | |
|---|---|---|---|---|
| Name (Full): | | | Date of Incident: / / | Time of Day: |
| Employee ID #: | | | Date Reported to Supervisor: / / | Time of Day: |
| Job Title: | | ☐ Male ☐ Female | Work Address: | |
| Telephone #: | | | | |
| Department: | | | Incident Location (address, Building name, office, cross streets, fire name, woods, facility, room #, etc.): | |
| Agency/University: | | | | |
| Supervisor: | Phone #: | | | |
| Date Hired: | Time in Current Job: | | County: | |

**Witness Information**

Were there any witnesses to the incident? ☐ Yes ☐ No Number of Witnesses (if applicable): _____

If yes, list all known witnesses/phone #'s below, please include additional names on attachment if needed.

Name: Phone #:

Name: Phone #:

**Medical Information**

Part(s) of the body injured:

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? ☐ Yes ☐ No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

**Description of Accident/Incident**

**What was the root cause of the incident? Ask why, and then ask why again. (e.g. Why? I slipped on scrap metal. Why? The work area was not cleaned up. Why? I was rushing to get project done and did not take time to clean up the work area.)**

**Suggested Corrective Actions**

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Employee Name Signature Date / /

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# Appendix B: Leave Options Form

Workers' Compensation
STATE HUMAN RESOURCES

## EMPLOYEE USE OF LEAVE OPTIONS FORM

The following leave options are available during the seven (7) day waiting period to receive temporary total disability (TTD) benefits for an injured employee that loses time from work as a result of an on-the-job injury that is determined by their employing agency to be compensable.

**Check one of the options below to elect leave usage for the seven (7) day waiting period.**

- ☐ **Option 1:** Elect to take sick or vacation leave during the required seven-day waiting period and then go on workers' compensation leave and begin drawing workers' compensation weekly benefits.
- ☐ **Option 2:** Elect leave without pay for the seven-day waiting period and then began drawing workers' compensation weekly benefits.

*Note:* In either option above if the injury results in disability of more than 21 days, the workers' compensation weekly benefit shall be allowed from the date of the disability.

**Check one of the options below to elect the option to supplement workers' compensation payments after the seven (7) day waiting period.**

- ☐ **Option 1:** Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Human Resources. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation.
- ☐ **Option 2:** Elect workers' compensation payments without supplemental leave usage.

*Note:* All elections involving use of earned sick or vacation leave are subject to their availability at the time of the injury.

By signing below, I certify that in the event of any overpayment of wages or workers' compensation benefits, such amounts shall be deducted from future benefits owed or immediately repaid in cash by the employee. This election may only be changed by completing a new form.

| | |
|---|---|
| Employee Name (print) | Date of Injury |
| Employing Agency | Division/Unit |
| Employee Signature | Date |

**Supervisor Completes This Section**

The above named employee was injured on _____ (Date of Injury) and was placed on workers' compensation leave effective _____ (Date of Disability). I completed an Incident Investigation Report for this injury and submitted it to my agency's workers' compensation administrator along with all information necessary to complete the Industrial Commission Form 19, Employer's Report of Employee's Injury of Occupational Disease to the Industrial Commission.

| | |
|---|---|
| Supervisor Name (print) | Title |
| Supervisor Signature | Date |

# Appendix C: Supervisor Incident Form (2 pages)

## NORTH CAROLINA SUPERVISOR INCIDENT INVESTIGATION REPORT

**Instructions: Begin investigation within 24 hours and attach the Employee Incident Report and Witness Reports to this report. Forward all reports within 72 hours to the Program Administrator. If more room is needed, continue in a Word document and attach it to this submission.**

| | |
|---|---|
| **Agency/University:** | **Date of Incident:** |
| **Employee Name:** | **Employee Phone #:** |
| **Incident Supervisor:** | **Supervisor Phone #:** |

**Incident Classifications (check all that apply)**

☐ Near Hit ☐ Injury ☐ Fatality ☐ Property Damage ☐ Spill ☐ Possible Blood Borne Pathogen exposure

**Employee required:**

☐ First-Aid Only ☐ Medical treatment and released ☐ Hospitalized ☐ Other:

**Employee:**

☐ Returned to work no restrictions ☐ Returned to work with restrictions ☐ Did not return to work (Lost Days)

**Hazard Types (select one based on origination of injury in this preference order)**

☐ Violence or injuries caused by people or animals ☐ Transportation ☐ Fires or Explosions
☐ Slips, Trips, Falls Surface Level ☐ Fall from Elevation ☐ Exposure to harmful substances or environment
☐ Contact with objects or equipment (Struck By, Struck Against, Caught-on, Caught between, Puncture, Cut) ☐ Over-Exertion (lifting)
☐ Bodily Motion (reaching, twisting, running) ☐ Other (List Here):

**Names of Witnesses Interviewed:**

**Incident Information**

**Describe the specific activity the employee was engaged in and the sequence of events. Include objects or substances that directly injured or made the employee ill. Describe tools, equipment, and PPE in use. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)**

| | | |
|---|---|---|
| **Is the activity part of the employee's normal job?** ☐ Yes ☐ No | **Prior to beginning activity, did the employee review potential hazards/dangers?** ☐ Yes ☐ No | **Date employee last received training for the activity.** / / |

**What was the root cause of the incident? Ask why then ask why again (e.g. Why? The employee slipped on scrap metal. Why? The work area was not cleaned up. Why? The employee was rushing to get a project done and did not take time to clean up the work area.)**

**Action taken or will be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)**

**I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.**

| | | |
|---|---|---|
| **Supervisor's Name:** | **Signature** | **Date of Report:** / / |
| **Manager's Name:** | **Signature** | **Date Reviewed:** / / |

**The Supervisor will obtain the Managers' signature and forward signed copies of the Employee Report, Witness Statements, and the Supervisor's report to the Program Administrator. The Program Administrator will send the Employee's and Supervisor's reports to the Manager's supervisor, Local Safety Contact, Safety Committee Chairperson, and Agency Safety Director within two business days. The WCA will receive all reports and all supporting documentation.**

| | | |
|---|---|---|
| **Program Administrator Name:** | **Signature** | **Date** / / |

**Date Corrective-Actions Completed:**

**January 2015**

## NORTH CAROLINA SUPERVISOR'S INCIDENT INVESTIGATION REPORT – PAGE 2

**ACCIDENT BREAKDOWN BY CHARACTERISTIC**
**(check all that apply)**

### Nature of Injury

- ☐ Amputation or Enucleation
- ☐ Assault
- ☐ Burn or Scald
- ☐ Contusion, Bruise
- ☐ Electric Shock
- ☐ Eye, Foreign body in
- ☐ Fracture, Broken Bone
- ☐ Freezing, Frostbite
- ☐ Hearing Loss or Impairment
- ☐ Heat Exhaustion, Sunstroke
- ☐ Hernia or Rupture
- ☐ Infection
- ☐ Inhalation Injury-Toxic Substance
- ☐ Insect Bites
- ☐ Laceration (Cut )
- ☐ Multiple Injuries
- ☐ Needle Puncture
- ☐ Rash, From Plants
- ☐ Rash, Not From Plants (Dermatitis)
- ☐ Scratches, Abrasions
- ☐ Sprain, Strains
- ☐ Other

### Part of Body Affected

- ☐ No Physical Injury
- ☐ Head
- ☐ Neck
- ☐ Eyes (Including Vision)
- ☐ Arm(s) (Above Wrist)
- ☐ Hand(s) (Including Wrist)
- ☐ Finger(s) and Thumb(s)
- ☐ Upper Extremity, Multiple Parts (shoulder, arm, forearm, wrist, or hand)
- ☐ Abdomen (Including Internal Organs)
- ☐ Back (Including Muscles, Spine)
- ☐ Chest (Including Internal Organs)
- ☐ Hips (Including Pelvic Organs)
- ☐ Shoulder(s)
- ☐ Trunk, Multiple Parts
- ☐ Leg(s) (Above Ankle)
- ☐ Foot (Including Ankle)
- ☐ Toes
- ☐ Lower Extremity, Multiple Parts (from the hip to the toes)
- ☐ Multiple Parts of Body, Severe
- ☐ Digestive System
- ☐ Respiratory System
- ☐ Circulatory System
- ☐ Skin
- ☐ Other

### Type of Accidents

- ☐ Bodily Reactions (Sprains, Strains, Rupture, Etc.)
- ☐ Caught In, Under, Or Between
- ☐ Contact With Temperature Extremes (Fire, Cold)
- ☐ Disease Exposure
- ☐ Electrical Shock
- ☐ Falls (All Types)
- ☐ Noise Exposure
- ☐ Repetitive Motion
- ☐ Rubbed Or Abraded By Object
- ☐ Struck Against Object
- ☐ Struck by Flying Object
- ☐ Struck by Other Object/Person
- ☐ Toxic Materials Exposure
- ☐ Vehicle or Equipment Accident
- ☐ Other

### Safety Equipment in Use

- ☐ Hard Hat
- ☐ Safety Glasses
- ☐ Goggles
- ☐ Face shield or welder helmet
- ☐ Gloves
- ☐ Fire Shirt
- ☐ Fire Pants
- ☐ Safety Shoes
- ☐ Fireline Boots
- ☐ Ear Protection
- ☐ Respirator
- ☐ Lanyards & Lifelines
- ☐ Fluorescent Vests
- ☐ Buoyant Work Vest
- ☐ Warning & Control
- ☐ Seat Belts
- ☐ Shoulder Harness
- ☐ Safety Equipment, National Electrical Code (NEC)
- ☐ Lab Coat
- ☐ Other

**When submitting this report, include pictures of incident location, equipment in use, the vehicle used (if applicable), and any third party reports (i.e. Police Report, OSHA Report, etc.).**

# Appendix D: Witness Statement Form

## NORTH CAROLINA WITNESS STATEMENT FORM

**Instructions: Before providing the required information below, please note that you will have to certify the truthfulness of this information. You will also be required to acknowledge that you understand that in addition to being disciplined for providing false and/or misleading information, up to and including dismissal, you may also be subjected to additional criminal and/or civil liability. To help you write this statement, please include, if possible, the following information:**

**Type of Investigation:**

☐ Safety Incident ☐ Accident Review ☐ Near Hit ☐ Property Damage

| **Witness Information** | |
|---|---|
| **Name:** | **Title:** |
| **Work Address:** | **Work Phone #:** |
| **Incident Information** | |
| **Date of Incident:** | **Time of Incident:** |
| **Location of Incident:** | |
| **Do you have any pictures of the incident? If yes, please attach them to this submission.** ☐ Yes ☐ No | |
| **List the names of anyone present who observed or may have knowledge of the incident.** | |
| **State what you know about the incident. Indicate who, what, where, and when. Be as specific as possible. If you need more space than what is provided here, create a Word document and attach it to this submission.** | |

**I hereby certify that the information I have provided is true and accurate. I acknowledge that any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.**

| | |
|---|---|
| **Witness Name:** | **Witness Title:** |
| **Signature:** | **Date of Statement:** / / |

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# Appendix E: Reporting Accidents to OSHA

## Protocol for Reporting Amputations, Loss of Eye(s), Hospitalizations, and Fatalities

**For injuries involving state, contract or temporary employees that result in a fatality employers must report to OSHA within (8) hours. For amputation, loss of eye(s) or hospitalization involving state, contract or temporary employees, OSHA must be contacted within (24) hours. The following action steps shall be completed immediately for these events!**

1. Call your Agency/University Human Resources Director and your Agency/University Safety Leader. In the event of a fatality, also contact your Agency/University Legal Counsel.

2. Call the NC Department of Labor during working hours (8 a.m. to 5 p.m.) at 919-779-8560 or 1-800-625-2267. After working hours, (5 p.m. to 8 a.m.), weekends or holidays, call State Capitol Police at (919) 733-3333. **(See below)***

3. Call a member of the OSHR Safety, Health and Workers' Compensation Division.

| Name and Title | Telephone | Email | Fax |
|---|---|---|---|
| John Bogner, Safety and Health Director | (919) 807-4897 | John.Bogner@nc.gov | (919) 733-0653 |
| Doug Gaylord, Safety and Health Manager | (919) 807-4877 | Doug.Gaylord@nc.gov | |
| Kathy Conner, Safety Consultant | (919) 807-4824 | Kathy.Conner@nc.gov | |
| OSHR Main Number | (919) 807-4800 | | |

***NOTE:*** *Be prepared to provide contact information, addresses and telephone numbers for each person(s) involved.*

4. Follow-up with an e-mail or fax to OSHR staff listed above. All e-mails and faxes are public information – Be sensitive and utilize discretion when describing the incident details.

**The Office of State Human Resources will notify the Governor's Office. The responsibility of OSHR is to assist in the investigation of the incident.**

**Effective January 1, 2015:** Employers are required to contact OSHA for all work-related, in-patient hospitalizations, all amputations, and all losses of an eye within 24 hours. An amputation is the traumatic loss of a limb or other external body part. An amputation is defined as an act where a part of the body, such as a limb or appendage, has been severed or cut off (either completely or partially). Amputations also include the following:

- Fingertip amputations with or without bone loss
- Medical amputations resulting from irreparable damage
- Amputations of body parts that have since been reattached

Amputations do not include avulsions (tissue torn away from the body), enucleations (removal of the eyeball), deglovings (skin torn away from the underlying tissue), scalpings (removal of the scalp), severed ears, or broken or chipped teeth.