Accident/Incident Report

Phone: (512) 393-2232
Fax: (512) 393-2227

The Accident Report must be submitted to the Human Resource Department within 24 hours. Send the original form to the Human Resources Department in person or inner office mail. To report injuries occurring after normal working hours and on weekends please call (512) 393-2232 and leave a message.

Date of Incident:_____**Date Reported:**_____**Incident is:** ☐ **Medical** ☐ **Fleet / Property**

RECORD ONLY ☐ (In house report - no treatment necessary) **REPORTABLE** ☐ (Treatment is needed or has been sought)

Employee Information:

Employee's Name: _____

Employee's Mailing Address: _____County: _____

Personal Email Address: _____

Phone Number: _____Work Phone Number: _____

Job Title/Position: _____ EE#/SO#: _____Age: _____

Social Security Number:_____/_____/_____Date of Birth: _____Sex: M ☐ F ☐

Work Hours: Begin:_____a.m. -_____p.m. End:_____p.m. -_____a.m.

Regular work-days: **For HCSO Only –** Blue Shift ☐ or White Shift ☐

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Supervisor's Name and Contact Information:

Supervisor's Name and Title: _____

Supervisor's Phone Number: _____

Incident Information: Time of Incident Occurred:_____a.m./p.m.

Address of Incident (Please give complete address, including county):

_____

_____

Location of Incident (ex: hallway, cell block, booking, CR, FM):

_____

_____

Day of the week incident occurred:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Experience in occupation at the time of incident:

☐ Less than a month ☐ 1 - 5 months ☐ 6 months - 1 year ☐ 1 - 4 years ☐ 5 or more years

Was the employee working: ☐ alone ☐ with co-worker(s) _____

At the time of the incident was the employee ☐ on break ☐ working overtime ☐ entering/leaving building ☐ performing work duties ☐ at lunch ☐ other _____

In detail describe specific injured area(s) (ex: right shoulder, left ankle, etc.): _____

_____

Nature of the injury or illness:

☐ Puncture	☐ Abrasion	☐ Insect/Animal Bite
☐ Laceration	☐ Skin Disorder	☐ Foreign Body
☐ Fracture	☐ Burn	☐ Infection
☐ Bruise/Contusion	☐ Respiratory	☐ Muscle Strain
☐ Dislocation	☐ Irritation	☐ Muscle Sprain

Severity:

☐ First Aid ☐ Medical Treatment ☐ Fatality

Medical Attention:

If First Aid Only, who was the provider? _____

Was the employee sent to a: ☐ Doctor ☐ Hospital ☐ Urgent Care/24 Hour Facility

Hospital: ☐ Seton Hays in Kyle **Preferred Clinics:** ☐ Premier ER/Urgent Care ☐ FastMed Kyle

Other Location Name & Address: _____

Phone Number: _____ Fax Number: _____

*****Please Note** Hospital treatment requires a follow up visit to an Urgent Care or Physician who accepts WC insurance***

Auto/Fleet Incident:

If County Auto was damaged:

County Unit# Year/Make/Model & **VIN:**

Brief Description of Damage

Is it drivable? Yes ☐ No ☐ Where is unit currently located?

Accident worked by Case Number

Witness Name(s) Witness Contact Number(s)

Was damage the result of an intentional law enforcement action? Yes ☐ No ☐

If County Auto caused damage/injury to another person or property:

Injured Person or Property Owner Phone Number

Year/Make/Model of Vehicle or Property Description

Was anyone injured? Yes ☐ No ☐ Was anyone transported by ambulance for care? Yes ☐ No ☐

Brief Description of Damage

Is it drivable? Yes ☐ No ☐

Accident worked by | Case Number

Witness Name(s) | Witness Contact Number(s)

General Liability or Property Incident ***(ex. Animal, mailbox, pothole, windshield damage from rock):***

Property Owner Name | Property Owner Phone Number

Item Description and Damage Reported

If an animal was involved – is a claim by the owner expected due to injury/death of animal? Yes ☐ No ☐

Witness Name(s) | Witness Contact Number(s)

What conditions may have contributed to the cause of the incident?

- ☐ Close Clearance/Congestion
- ☐ Improper Technique
- ☐ Inadequate Ventilation
- ☐ Horseplay/Distractive Action
- ☐ Inadequate Tools/Equipment
- ☐ Lack of Skill
- ☐ Used Equipment Improperly
- ☐ Inadequate Housekeeping
- ☐ Failure to Warn/Signal
- ☐ Inadequate Maintenance
- ☐ Nullified Safety/Control Devices
- ☐ Other (specifiy):
- ☐ Hazardous Placement
- ☐ Under Influence of Drugs/Alcohol
- ☐ Illumination
- ☐ Inadequate/Improper PPE Use
- ☐ Lack of Knowledge/Training

For injuries caused by detainee/inmate: Will charges be filed? Yes ☐ No ☐

Witness(es) Statement (attach sheet for additional comments):

Employee's Description of Accident (attach sheet for additional comments):

Supervisor's Description of Accident (attach sheet for additional comments):

I certify that the information I provided in this report is true.
I understand that any falsification of information regarding an on the job injury may result in disciplinary actions. 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 Printed Name	*Supervisor on Duty Signature*	*Date*
Department Head Printed Name	*Department Head Signature*	*Date*
CPL/Sgt Printed Name	*CPL/Sgt Signature*	*Date*
Lieutenant Printed Name	*Lieutenant Signature*	*Date*
Captain Printed Name	*Captain Signature*	*Date*
Chief Deputy Printed Name	*Chief Deputy Signature*	*Date*
Human Resource Director Printed Name	*Human Resource Director Signature*	*Date*

Erik Granjeno

DEEP EAST TEXAS SELF INSURANCE FUND

Athens Administration

You can see any physician of your choice who will accept workman's compensation claims and who will accept payment according to the worker's compensation assignment. It is your responsibility to ensure that the medical provider you choose accepts worker's compensation (unless you ask HR to make an appointment for you).

If life-threating emergency exists, seek medical attention immediately - the paperwork can wait - but will have to be done as soon as it is possible.

Otherwise follow these steps:

Notify your supervisor of accident IMMEDIATELY
Or no late than 24 hours after accident. Notification is requires whether the incident or injury is major or minor.

Complete Accident/Incident Report IMMEDIATELY

- **Submit Accident/Incident Report** to supervisor or person in charge who will in turn submit it to Human Resource: *Melanie Munoz, melanie.munoz@hayscountytx.gov or 512-393-2227 (fax)*
- **Seek medical care.** The medical provider must accept our WC carrier. Notify HR of appointment date and time
- **Bring a copy of Accident/Incident Report** to first medical treatment (if possible)

Give medical provider the following information for billing:

Athens Administration
P.O. Box 969
Concord, CA 94522

Phone: 866-482-3535
Fax: 925-609-5306(Billing)
Fax 925-889-2410(Office)

Give Pharmacy the following information:
RxBridge
Athens Administration

Provide Your Name & SS# to the Pharmacist

For issues or concerns obtaining your medications, call the Help Desk at 833-792-7434 for assistance 24/7.

CLAIM NUMBER: will change for each original injury claim.

If you have any questions, contact **Melanie Munoz** in Human Resources by email **melanie.munoz@hayscountytx.gov** or by phone
512-393-2232