City of De Pere Supervisor Instructions For Completing And Reporting
Report of Injury, Exposure, or Illness

☐ Injured employee notifies supervisor of injury. As soon as possible, but no later than prior to the end of the employee's work shift of the day of injury, the employee calls the EMC On Call Nurse at 844-322-4668. The call should be made with the supervisor, if possible. All injuries, no matter how minor, should be reported. If injury/exposure causes a need for inpatient hospitalization and/or is life threatening contact the department head and Human Resources Director at 339-4045 or 621-9236.

Reminder: If there is a potential bloodborne pathogen exposure, the employee should follow the source person to the hospital/doctor's office. If unable to follow the source person, go to the doctor's office during normal business hours or the emergency room after normal business hours. Report the exposure and the doctor will determine if there has been a true exposure.

☐ Remind employee that they must obtain a work restriction form from the provider if they seek medical treatment and that the City offers light-duty for employees injured at work. Copies of the Work Related Injury/Illness Report form are available at www.deperewi.gov/hrforms.

☐ **Inform Human Resources as soon as possible if the employee seeks medical treatment or misses any work due to the injury**. If an employee is authorized off of work, Human Resources may follow up with the provider to ensure they know light-duty is available and the employee is returned to work as soon as possible.

☐ Complete the Supervisor's Accident Investigation form. If there was a bloodborne pathogen exposure, please complete the bloodborne pathogen exposure form.

☐ Forward Supervisor's Accident Investigation form to the department head or designee (if applicable). Department head must sign off on the Supervisor's Accident Investigation form.

☐ Department head sends original investigation form (make copies for department if desired) to Human Resources.

Make certain the employee gives you a legible work restriction document after returning from his/her medical appointment. This work restriction can be faxed to Human Resources, 339-4049, emailed, or hand-delivered as soon as possible. The employee must provide a return to work after EACH visit to the provider, with the exception of physical therapy appointments.

The following medical facilities are the preferred workers' compensation treatment centers. If the employee needs medical treatment due to a work related injury or illness, employee may seek treatment at:

Bellin Health - Concentra Occupational Health Clinic Phone: 920-305-0360	**Nova Medical Center** Phone: 920-787-5777	**PREVEA** Prevea Urgent Care: (920) 496-4700Prevea Occupational Health: (920) 405-1420 *Please call ahead as appointments are needed.*		
2920 Ramada Way Green Bay, WI 54304	1620 S Ashland Avenue Green Bay, WI 54304	*Occupation Health* 2502 S Ashland Ave Green Bay, WI 54304	*Urgent Care* 3860 Monroe Road De Pere, WI 54115	*Urgent Care* 1601 Lawrence Drive De Pere, WI 54115
NOTE: Use of the provider listed is voluntary and choosing to use an alternate provider that is not listed will not affect your employee benefits under state workers' compensation laws.				

For a SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day) employee should seek immediate treatment at the nearest emergency facility. Hospitals include, but are not limited to:

BELLIN MEMORIAL HOSPITAL 744 S WEBSTER AVE GREEN BAY, WI 54301 (920) 433-3500	**ST. MARYS HOSPITAL** 1726 SHAWANO AVE GREEN BAY, WI 54303 (920) 498-4200	**AURORA BAYCARE MEDICAL CENTER** 2845 GREENBRIAR RD GREEN BAY, WI 54311 (920) 288-8000	**ST. VINCENT HOSPITAL** 835 S VAN BUREN ST GREEN BAY, WI 54301 (920) 433-0111

City of De Pere - Supervisor's Accident Investigation
Loss Source Identification

When Date/Time of Accident _____ Report to supervisor or first aid delayed Yes _____ No _____ If yes, why? _____

Who Injured Person's Name_____ Department_____

Job Title: _____

Injury/Loss Nature/extent of injuries. Include parts of the body and medical treatment administered.

_____

_____

Where Exact location where accident occurred

_____

_____

What/How Type of accident (use code from below) Injury (1-10) _____

Accident Code (Check all that apply)

Injury

1. Fall from elevation
2. Fall same level
3. Struck by
4. Caught in, under, or between
5. Overexertion
   - Push/pull
   - Lift/lower
   - Carry/hold
6. Cumulative trauma disorder
7. Electrical contact
8. Fumes, dust, gas, caustics, noise, etc.
9. Motor vehicle
10. Other (describe): _____

Was employee doing something other than required duties at time of accident? Yes_____No_____

If yes, what and why?_____

_____

Was a safety policy or procedure violated? Yes_____No_____

If yes, please explain: _____

Description of accident: What employee was doing; how he/she was doing it; and any physical object including weights, tools, machines, structures, or equipment involved.

_____

_____

_____

Why Check accident causes and comment fully here.

_____

_____

Prevention

What should be done and by whom to prevent recurrence of this type of accident? Include target dates:

_____

_____

_____

What action are you taking to see that this is done? Include target dates and responsible party.

_____

_____

_____

Accident Cause Analysis (check all that apply)

ENVIRONMENTAL

___ **Inadequate safeguards**

Lack of handling or safety devices, unsafe design; unguarded machinery, lack of safe work

___ **Improper or defective equipment**

Poorly maintained, broken, cracked, rough, slippery, worn equipment, inappropriate personal protective equipment

___ **Location hazards**

Poor layout; congestion; insufficient space for storage; poor lighting, etc.

___ **Poor ergonomics**

Heavy lifting, poor workstation design; excessive bending, twisting or reaching; inadequate tools

___ **Poor housekeeping**

Improper piling or placing; clutter, spillage or breakage

___ **Not otherwise classified**

PERSONAL

___ **Bodily conditions**

Physical impairment; illness; fatigue, emotional upset; intoxication

___ **Lack of skill or knowledge**

Improperly trained; inexperienced; uninformed; unaware, etc.

___ **Adequate skill or knowledge but failure in execution**

Chance-taking; unauthorized or unnecessary use of equipment or tools; failure to use or deliberately making safety or control devices ineffective; failure to do what should have been done in the particular situation

___ **Improper apparel**

Failure to use personal protective equipment (eye, face, foot, hand, head, hearing, respiratory, etc.,): loose clothing, jewelry, etc.

___ **Not otherwise classified**

Supervisor's Signature _____ **Date** _____

Dept. Head Comments _____

_____

Dept. Head Signature _____ **Date** _____

City of De Pere
Complete Only For Bloodborne Pathogen Exposure Incidents
Exposure Information

This form is only to be used for exposure to a bloodborne pathogen.

Employee Name _____

This form is to only to be used to report an exposure to a bloodborne pathogen.				
Route: (please check all that apply) ☐ Eyes ☐ Non-Intact Skin ☐ Needle/syringe ☐ Nose ☐ Mouth ☐ Other ☐ Bite ☐ Scratch				
Estimated amount and type of fluid exposed to, if known:				
Was area cleansed/flushed ? Describe:	☐	Yes	☐	No
Was personal protective equipment (PPE) used?	☐	Yes	☐	No
Did PPE fail? e.g., was glove torn?	☐	Yes	☐	No
Was clothing contaminated?	☐	Yes	☐	No
Clothing sent for cleaning? If yes, where and date:	☐	Yes	☐ If no, why:	No
Exposure treatment/testing initiated? If yes, list medical provider and date:	☐	Yes	☐	No
Other information:				