CITY OF MEDFORD
ADMINISTRATIVE REGULATION

Regulation No.	85-6-R Revised 11/6/86
Page	1 of 7
Subject Area	Personnel
Date of Issue	August 7, 1985
Supersedes Regulation No.	N/A

Title SAFETY AND HEALTH

I GENERAL POLICY STATEMENT

The City is committed to providing a safe and healthful working environment for all of its employees. The City recognizes the need to stress safety in all of its operations in order to reduce the risk of accidents which cause personal suffering, loss of productivity, financial liability and damage to City property.

II PURPOSE

The purpose of this regulation is to address the City's safety and health practices, establish guidelines and responsibility for its coordination and administration.

III AUTHORITY

City Manager.

IV GENERAL RESPONSIBILITIES

A. Safety Officer

The Personnel Officer is the City's Safety Officer responsible for the coordination and proper administration of all city-wide and inter-departmental safety programs under the direction of the City Manager. The Safety Officer shall be responsible for the following:

1. Maintain and monitor compliance with applicable State and Federal Safety Laws and Regulations.
2. Coordinate Safety Committee activities.
3. Advise and train supervisors regarding accident claims and reporting systems.
4. Serve as liaison with State and Federal safety agencies.
5. Coordinate First Aid and Audiogram programs.
6. Maintain all safety records and statistics and prepare related reports as required.
7. Coordinate general City-wide and inter-departmental safety programs.
8. Serve as advisor to departments in development and maintenance of intra-departmental safety programs.

IV GENERAL RESPONSIBILITIES (Continued)

B. Department Heads

1. Ensure that City property and equipment under their control is free of hazards.
2. Develop general safety departmental rules.
3. Ensure that Departmental safety rules are posted in such a manner as to be readily available to all employees.
4. Ensure that injuries are reported within 24 hours and accurately recorded.
5. Implement corrective action in cases of accidents and/or reported hazards.
6. Monitor/administer disciplinary actions taken against subordinate employees for safety violations. Include safety performance as a factor in performance evaluations and merit reviews.
7. Report to the Safety Officer any notice or citation by State or Federal safety agencies for failure to comply with required safety standards.

C. Supervisors

1. Have working knowledge of applicable health and safety codes.
2. Instruct employees in safe work procedure and the safe use of equipment and tools.
3. Monitor compliance with all department safety rules including the proper use of all protective safety devices, equipment, and clothing.
4. Correct any safety related deficiencies in tools or equipment.
5. Thoroughly investigate all accidents and determine their causes and needed corrective action.
6. Take immediate action to eliminate any known hazardous condition or procedure.
7. Counsel employees and use disciplinary action if necessary as a corrective measure for safety violations.
8. Consult with Department Head on all safety problems that cannot be corrected at the line supervisor level.

D. Employees

1. Become familiar with and follow all established safety rules and regulations pertaining to their job.
2. Refrain from acting in a manner that would create a safety hazard or risk causing an accident.
3. Report immediately any unsafe work condition, equipment or procedure to their immediate supervisor.
4. Report immediately to their supervisor any on-the-job accident resulting in injury, illness, or property damage. Failure to report such an accident may result in disciplinary action.
5. Report any medical attention received relating to City work or outside employment work related injury/illness.

V SAFETY EDUCATION AND TRAINING

Accident prevention is a key element in the City Safety Program. Training is essential to help prevent accidents and to instill safety consciousness in the work environment. Departments are responsible for providing such a training program on at least a quarterly basis to all department employees. The Safety Officer is available to assist departments in obtaining the resources and expertise necessary to accomplish the training which may include films, presentations by consultants, "tool box" discussions, and any other suitable training material. Departments will maintain a record of these training sessions to include the date given, subject, and employees attending.

VI HAZARD MANAGEMENT

Accident prevention must include a systematic review of the workplace to identify safety hazards. Preventive maintenance and good housekeeping are by themselves not enough. Hazards may go unnoticed simply because they have not contributed to an accident or near miss. Therefore, Department Heads will be responsible for having all work areas under their control inspected at least on a monthly basis. In addition, any reported hazard shall be inspected immediately. The monthly inspections shall include not only the facilities and machinery, but the environmental factors such as noise, lighting, and temperature. Any identified hazards shall be eliminated as soon as practicable. If a hazard poses a serious and imminent threat and cannot be immediately eliminated, the department head shall authorize a shutdown of work in the hazardous area until the hazard can be eliminated.

VII SAFETY EQUIPMENT

Where necessary, the City will provide safety equipment to ensure the well-being of the employees. These items may include safety glasses, gloves, safety shoes, respiratory equipment. Employees must use all safety equipment required and/or necessary to the performance of their work.

VIII OCCUPATIONAL INJURY/DISEASE REPORTING PROCEDURES

An integral part of the City's safety program is the development of a responsive claims reporting system in the event of an on-the-job injury/disease. Once an injury or disease occurs, it is essential that the claim be processed rapidly and appropriately and that the necessary follow-up investigation be initiated.

The goal of the City is to help an injured employee recover as quickly and completely as possible in order to return the employee to productive work. The key to achieving this goal is effective and timely communications.

VIII OCCUPATIONAL INJURY/DISEASE REPORTING PROCEDURES (Continued)

Following are the steps to be followed in reporting a job related injury or disease.

A. Determine if Medical Attention Required

1. A judgement must be made by the supervisor and the employee to ascertain if medical attention is required. If medical attention is required, obtain the required attention immediately, i.e. first aid, hospital emergency room care or doctor's office. The Supervisor should insist on medical attention for the employee if there is any doubt as to the employee's well being or their ability to perform their job.
2. Injuries or diseases requiring hospitalization of an employee as an in-patient for more than 48 hours, or when a fatal accident occurs shall be reported immediately by the Supervisor to the Department Head and to the Personnel Office.
3. When the employee leaves the work site to obtain medical attention, the supervisor must instruct the employee to obtain a written release from the doctor before he or she will be allowed to return to work.

B. Complete the Supervisor's Occupational Injury/Disease Investigation Report ALL/010

1. Supervisors are responsible for conducting a thorough and timely investigation of each reported injury/disease to determine the who, what, when, where and why of an injury/disease.
2. The Supervisor's Occupational Injury/Disease Investigation Report must be completed for all reported occupational injury/diseases.
3. All sections of the Investigation Report Form PERS/018 must be completed by the supervisor except the portion reserved for the Safety Committee review. A copy of this form is attached to this regulation, as Exhibit "A".

   Use of this form is self explanatory. Do not leave any section blank. Write in NA if not applicable.

4. Knowledge of the definitions of the following terms will assist in completing this form:

   UNSAFE ACT - An isolated action by an employee involving a recognized hazard which has been forbidden by a law, or rule.

   UNSAFE PRACTICE - Actions of employee or employees which are unsafe but perhaps have not been recognized as being unsafe or actions which have been recognized as unsafe but which are common occurrences.

VIII OCCUPATIONAL INJURY/DISEASE REPORTING PROCEDURES (Continued)

5. When the cause of the injury/disease has been determined and hazards removed or work practices corrected, the supervisor will review the corrective action with the employee.

C. Complete the 801 Report of Occupational Injury/Disease

1. An 801 Report form must be completed for any occupational injury/disease requiring medical attention or if an employee requests an 801 Form to report an injury/disease not requiring medical attention.

2. The worker's section of the 801 Form must be completed by the employee unless he or she is incapacitated and unable to complete.

3. Instructions for completing the 801 are included with a sample 801 as Exhibit B.

D. Submit Report(s) Forms to PERSONNEL

The completed 801 Report and the Investigation Report Form PERS/018 must be sent to PERSONNEL within 24 hours of the injury/disease report or on Monday if the injury/disease occurs on the weekend.

IX REPORTING DELAY & AGGRAVATION PROCEDURES

A. Reporting Delay

1. Employees must be directed to report injuries upon occurrence to their supervisor.

2. Handle a late report of an injury/disease as outlined in Section VIII of this regulation.

3. With the Supervisor's submittal of the Investigation Report, include all of the employee's activities since the injury/disease occurred.

B. Aggravation of Injury/Disease

1. The Supervisor must review with the employee the circumstances relating to the aggravation of the previous injury.

2. The Supervisor should insist upon medical attention for the employee if there is any doubt as to the employee's well being or their ability to perform their job.

3. If a new incident occurs which aggravates a previous injury and it results in medical treatment or time loss, follow the procedures outlined in Section VII of this regulation.

IX REPORTING DELAY & AGGRAVATION PROCEDURES (Continued)

4. If a previous condition worsens naturally, the employee's doctor should reopen the previous claim. A new 801 should not be filed in such a case.

5. If the aggravation of the injury/disease is related to a previously reported incident and it involves times loss, the Supervisor must send to PERSONNEL a narrative report attached to the employee's City Leave Request Form PER/003 (see Exhibit "C") explaining the circumstances relating to the aggravation of the injury/disease. The employee's leave time must be designated "I" for Injury on the Leave Form.

X DOCTOR'S RELEASE

If medical attention is received for any occupational injury/disease, an employee must have a doctor's release upon returning to work. This requirement for a doctor's release includes medical attention received after the initial filing of a claim by the employee. Example: A firefighter complains of back pain after fighting a fire, but does not go to the doctor immediately, a week later, on his own time, he visits his doctor. The firefighter must get a release from the doctor before he returns to work.

The employee MAY NOT return to work without the appropriate doctor's release which states that the employee may return to work and under what conditions, if any, the employee may work without risk of aggravating the injury/disease.

XI LIGHT DUTY

No employee shall be returned to light duty work without the approval of the City Manager.

XII VEHICLE ACCIDENTS

In the event of an accident involving a motor vehicle, the Medford Police Department or other appropriate law enforcement agency shall be contacted. The Medford Police Department will investigate any accident which occurred on a public right-of-way within the City of Medford. In special circumstances, the Medford Police Department may be called on to investigate outside the City limits. The Police report of the accident shall be submitted to Personnel and the City Attorney's office along with a written narrative from the employee and supervisor describing the accident. (City of Medford form ALL/008)

XII VEHICLE ACCIDENTS (Continued)

Procedure for operator of City vehicle:

1. Make contact immediately with your supervisor and the police department. Do not make any statements as to your involvement to anyone other than your supervisor of the police officer(s) investigating the accident.

2. Do not move the vehicles involved unless it is necessary to care for injured, or to leave the vehicles could cause further injuries.

3. Get the names, addresses and phone numbers (work and home) of all witnesses.

4. Obtain vehicle identification and identification of operator(s) of vehicles involved.

5. Remain at all times with your vehicle unless injuries do not permit.

6. Do not provide any first-aid, other than what you are trained for. Do not move injured persons. Transportation will be provided by an ambulance.

XIII ACCIDENTS INVOLVING THE PUBLIC

All accidents involving the public shall be reported immediately to the City Attorney. Employees should not discuss the question of responsibility or liability with anyone pending advice from the City Attorney.

EXHIBIT A

CITY OF MEDFORD
SUPERVISOR'S ACCIDENT/DISEASE INVESTIGATION REPORT
SAFETY COMMITTEE REVIEW

INSTRUCTIONS: Supervisor is to complete form and forward all copies to Personnel within 24 hours of knowledge of accident (or on Monday if incident occurs on weekend). Following Safety Committee review, copies will be returned for the department and the employee. Refer to AR 85-6, Safety and Health, for additional information on occupational injury/disease reporting procedures. Incomplete forms will not be accepted.

DEPARTMENT/DIVISION _____

EMPLOYEE'S NAME _____ POSITION TITLE _____

SUPERVISOR'S NAME _____ POSITION TITLE _____

DATE OF INJURY _____ TIME _____ DATE REPORTED TO SUPERVISOR _____ TIME _____

LOCATION OF ACCIDENT _____

WITNESSES _____

DESCRIPTION OF INJURY:

Body Part Injured: ☐ Left ☐ Right

☐ Head ☐ Neck ☐ Chest ☐ Wrist ☐ Hip ☐ Ankle ☐ Other _____
☐ Face ☐ Shoulder ☐ Abdomen ☐ Hand ☐ Leg ☐ Foot
☐ Eye ☐ Back ☐ Arm ☐ Finger ☐ Knee ☐ Toe

Nature of Injury:

☐ Abrasion ☐ Bruise ☐ Strain ☐ Infection ☐ Exposure to Hazardous Material
☐ Laceration ☐ Fracture ☐ Dermatitis ☐ Foreign Body ☐ Fatality
☐ Puncture ☐ Sprain ☐ Burn ☐ Loss of Consciousness ☐ Other _____

Action Taken: ☐ First Aid ☐ Sent to Doctor ☐ Hospitalized

DESCRIPTION OF ACCIDENT:
(Explain sequence of events. Be specific--include the machine, object or substance involved; unsafe action by employee; unsafe conditions with regard to equipment, tools, clothing, or environment; failure to use proper safety equipment; failure to follow established safety procedures, etc. Attach additional page if necessary.)

REVIEW WITH EMPLOYEE/CORRECTIVE ACTION TAKEN:
(Training sessions; reinstruction on proper use of equipment or tools; use of safety equipment; establishment of rules or procedures; etc. Explain delay in reporting, if any. Attach additional page if necessary.)

Note: AR 85-6
Pages 5 + 6
Revised 11/6/86

Employee's Signature Date | Immediate Supervisor Date | Department Head Date

SAFETY COMMITTEE REVIEW: Accept Supervisor's Report: ☐ Yes ☐ No City-wide Impact: ☐ Yes ☐ No

Committee Recommendation:

Submitted by _____ Chairperson Date

Reviewed by _____ Safety Officer Date

White--Safety Committee File; Yellow--Employee's Personnel File; Pink--Department File; Goldenrod--Employee's Copy

ALL/010

SAIF CORPORATION
400 High Street, S.E. • Salem, OR 97312-1801

STATE OF OREGON
WORKER'S AND EMPLOYER'S
REPORT OF OCCUPATIONAL
INJURY OR DISEASE

For SAIF Customer Use
Area ____ ____ ____
Dept. ____ ____
Shift ____ CC ____

CLAIM NO. ____
SUBJECT DATE ____
CLASS ____
DEFAULT DATE ____
EMPLOYER'S ACCOUNT NO. ____

801 Reporting: 1-800-285-8525
801 FAX: 1-800-475-7785

FEIN of claim administrator: **93-6001769**
Insurer claim number:

1

Complete all items — Failure to do so may delay benefits.

WORKER

1. Worker's legal name (first, m.i., last):	2. Home phone: ( ) -	3. Date of birth: - -	4. Social Security Number (see back of form): - -
5. Worker's street address:	6. Male ☐ Female ☐	7. Education (No. of years completed or GED):	8. Hospitalized overnight as inpatient? (If emergency room only, mark "No") ☐ Yes ☐ No
Mailing address:	9. Nature of injury/disease (strain, cut, bruise, etc.):		10. Name and City of Hospital:
City State ZIP	11. Body part(s) affected: ☐ Left ☐ Right		12. Name and address of health insurance provider:
13. Date of injury/disease: - -	14. Time of injury: : ☐ a.m ☐ p.m.	15. Has body part been injured before? (If yes, explain) ☐ Yes ☐ No	16. Full name, address, and phone no. of attending physician: ( ) -

17. Describe accident fully (please print)

Witness(es):

18. **By my signature** I am giving **NOTICE OF CLAIM** and authorizing medical providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief (see paragraphs 3 and 4 on the back). **By my signature I also authorize the use of my SSN as described in paragraph 2 on the back. (If you do not authorize the use of your SSN as described in paragraph 2 on back, check here ☐.)**

Worker: Sign and give form to your employer for completion

X _____ - -
Worker signature *Date*

EMPLOYER

19. Employer's legal business name:	20. Employer BIN#:	***Employer: Complete items 24-27 only if worker is a leased employee.*** 24. Client's legal business name:	25. Client BIN#:
21. Employer's street address:	22. Employer FEIN:		
City State ZIP	23. Insurer policy #:	26. Client's street address: City State ZIP	27. Client FEIN:
28. Nature of business:	29. Worker class code:		
30. Worker's occupation (do not abbreviate):	31. Is worker an owner or corp. officer? ☐ Yes ☐ No	32. Address of injury site if different from 21 or 26: City State ZIP	
33. Date employer first knew of claim: - -	34. If fatal, date of death: - -		

This form satisfies OSHA Form 101 record-keeping requirements.

35. Date of hire: - -	36. State of hire:	37. Injured on employer's or client's premises? ☐ Yes ☐ No ☐ Unknown
		38. Did injury occur during course of job? ☐ Yes ☐ No ☐ Unknown
39. Date left work: - -	40. Time left work: : ☐ a.m ☐ p.m.	41. Date returned to regular work: - -
		42. Date returned to work with restrictions/light duty: - -
43. Working shift: → from : ☐ a.m ☐ p.m. to : ☐ a.m ☐ p.m.		44. No. of hours worked per shift:
		45. If returned to work with restrictions, were full wages paid? ☐ Yes ☐ No
46. Wage and wage period: $ ____ per ☐ Hr. ☐ Day ☐ Wk. ☐ Mo. ☐ Yr.		47. If wage varies or includes other earnings (tips, room and board, commission, etc.) give total weekly wage and explain. *(Attach payroll records for last 52 weeks prior to date of injury).*
48. Scheduled days off: S S M T W T F	49. No. of days worked per week:	$ ____

50. Department and location where event occurred:	51. All equip., materials, or chemicals employee was using when event occurred:
52. Specific activity the employee was engaged in when event occurred. (Indicate if activity was part of normal job duties):	
53. How injury or illness occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:	

54. Was accident caused by person (other than injured worker) or by failure of machinery or product? ☐ Yes ☐ No	55. Were other workers injured in the accident? ☐ Yes ☐ No	56. Is worker "Premium Exempt" (a Preferred Worker)? (If "Yes," attach copy of eligibility card.) ☐ Yes ☐ No	
57. Signature of employer representative: X	58. Print or type name and title:	59. Date: - -	60. Phone: ( ) -

DEPARTMENT OF CONSUMER & BUSINESS SERVICES
440-801 (6/97/COM)

Employer: Complete form and give worker Page 4 immediately as receipt of claim. Keep page 3. Send pages 1, 1A & 2 to insurer within five days of Notice of Claim.

Shaded fields are mandatory — WCD will return form to insurer if not completed.

Insurer's Copy

801

EXHIBIT B-1

Notice to W[illegible]r

Important information about your Social Security Number [illegible]

1. You must provide your SSN. [illegible] has authority to request your SSN under the Privacy Act of 1974, 5 USC & 552a (West 1977). Section [illegible] provided in Oregon Revised Statute 656 [illegible] under Administrative Order WCB [illegible] at OAR [illegible] Division [illegible]. Your SSN [illegible] out its duties under [illegible] Chapter 656 [illegible] and injured worker [illegible] administration.

2. Your voluntary authorization for the use of your SSN is also requested for [illegible]ory [illegible] including, but not limited to [illegible], child support enforcement, [illegible]ation, child labor [illegible] management, hazard [illegible] please check the box by your signature (in Section 18 on the front of this form).

Authorization to release medical records:

3. [illegible] this 801 you are giving [illegible] claim records to release [illegible] medical information relevant to the claim [illegible] a past history of the complaints of, or treatment of, a condition similar to [illegible] the same body part.

Caution against making false statements:

4. Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment is punishable, upon conviction, by imprisonment for a term of not more than one year or by a fine of not more than $1,000, or by both per ORS 656.990(1).

This is your receipt, when signed by your employer, that you gave notice of a claim. Keep it as your record.

5. Your employer will submit the claim for you. You will receive written notice from your employer's insurer of any action taken on your claim. If your employer is self-insured, the notice will be sent by your employer or the company your employer has hired to process its workers' compensation claims. The insurer must notify you of its acceptance or denial within 90 days from the date your employer knows of your claim. If denied, the reason for the denial and your rights will be explained.

Medical care:

6. If your claim is accepted, the insurer or self-insured employer will pay injury-related medical bills, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses you pay for claim-related treatment, up to a maximum established rate. Your request for reimbursement must be made in writing and include receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with the following exceptions: If you are required by your insurer to receive treatment from a managed care organization (MCO), necessary medical care, not otherwise covered by your health insurance, will be paid by your insurer until you receive a notice of denial or until three days after the insurer mails the notice of denial to you, whichever occurs first.

You must tell your doctor or hospital on your first visit that your injury or illness is work related. The doctor must tell you if there are any limits to the medical services he or she may provide you under the Oregon workers' compensation system.

Your attending physician must be one of the following:

- A licensed medical doctor, a licensed doctor of osteopathy, or a licensed oral and maxillofacial surgeon.
- A licensed chiropractor, but only for 30 days from the date of the first chiropractic visit on the initial claim or for 12 chiropractic visits during the 30-day period, whichever happens first.

OR

- If you are enrolled in a managed care organization (MCO), your attending physician may be any medical service provider authorized by contract with the MCO. An MCO contracts with insurance companies to provide managed medical care to injured workers of employers covered by the insurance company. Check with the MCO to find out who can be your attending physician.

Payments for time lost from work:

7. In order for you to receive payments for time lost from work, your attending physician must notify the insurer or self-insured employer of your [illegible] work. You will not be paid for the first three calendar days [illegible] unless you are [illegible] disabled for at least 14 consecutive calendar days or you are admitted as an inpatient to a hospital within 14 days of the first onset of total disability.

[illegible] more than three calendar days, the insurer or self-insured employer [illegible] compensation check no later than the 14th day after your employer knows of your claim. You will continue to receive a check every two weeks during your recovery period [illegible] time [illegible] of [illegible] up to a maximum equal to Oregon's average weekly wage. However, if your weekly wage is [illegible] or less, your benefits will be [illegible] per [illegible] percent of your weekly wage, whichever is less.

[illegible] questions about your claim that [illegible] your employer or [illegible]

Workers' Compensation Division
350 Winter Street NE, Salem, OR 97310
[illegible] (503) 947-7585, (TTY: (503) 947-7993),
[illegible]

OR

Workers' Compensation [illegible]
350 Winter Street NE, Salem, [illegible]
(503) 378-3351, (V/TTY: (50[illegible])
[illegible]

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

SAIF CORPORATION
400 High Street, S.E. • Salem, OR 97312-1801

Workers' Compensation Claim Form 801

T O P ! Read first ... ***Failure to provide clear and complete information may delay benefits or cause incorrect benefits to be paid.***

(1) Use ballpoint pen or typewriter, press firmly; write legibly.

(2) **Worker:** Failure to file a claim with your employer within 90 days of injury or within one year of learning you have an occupational disease may result in denial of your claim. Please read the information about your rights and responsibilities on the back of Page 4.

(3) **Employer:** Failure to report claim to your insurance company within five days of knowledge of the claim may result in untimely payment of time-loss benefits to the worker and a penalty to you or your insurance company. Submit the claim even if the worker is unavailable, unable to provide information, or unable to sign the form.

How to fill out a claim form *(items you may have questions about)*

Worker

7. Enter the number of years of education you have completed (high-school graduate or GED is 12, four years of college is 16, etc.).
8. If you were hospitalized past midnight, check "Yes."
9. Provide the type of injury (e.g., **cut** leg, **broken** arm).
11. Identify the body part(s) injured (e.g., low **back, leg** - right, **shoulder** - left, etc.).
13. Provide the actual date of accident, if an injury, or the date your condition first required medical attention, if an occupational disease.
15. If "Yes," briefly describe the prior injury (e.g., car accident in 1990, work injury in 1991, etc.).
17. Describe the accident as completely as possible. This will help the insurance company in handling your claim.
18. Read this important information as well as information on the back of the form: **"Important information about your Social Security Number (SSN)," "Authorization to release medical records," and "Caution against making false statements."**

Employer

This form satisfies OSHA Form 101 record-keeping requirements. See reverse.

20. Business Identification Number (BIN) is assigned by the Oregon Department of Revenue and is printed on your Oregon Tax Coupons (OTCs).
22. FEIN is your Federal Employers Identification Number.
24-27. If you are a "worker leasing company" as defined in Oregon Revised Statute 656.850(1), the businesses you provide workers to are your "clients." Complete this section only if your worker was injured while leased to a client.
28. Examples: truck manufacturing, retail grocery, log hauling, etc.
29. Enter the payroll class code under which you report this worker's earnings to your workers' compensation insurer.
33. Report the earliest of the following:
    — the date you first knew of a claim; or
    — the date you first knew of an accident or disease that may result in a compensable injury that requires medical services or causes time loss, permanent disability, or death.
50. E.g., Loading dock-north end, or Client's office at 452 Monroe Street, Washington, D.C., 20210.
51. E.g., Acetylene cutting torch, metal plate.
52. E.g., Cutting metal plate for flooring (indicate if activity was or was not part of normal job duties).
53. E.g., Worker stepped back to inspect work and slipped on some scrap metal. As she fell, worker brushed against the hot metal.
56. Check "Yes" if the worker presented a "Preferred Worker Eligibility Card" to you at the time of hire or you received a "Notice of Premium Exemption" from the Workers' Compensation Division (and the injury occurred on or before the eligibility end date on the card or notice).

Si Ud. tiene preguntas relacionadas a este formulario, comuníquese con la División de Compensación para Trabajadores, Sección de Beneficios, en Salem al número telefónico 947-7585, (TTY: (503) 947-7993), o (llamada gratis en Oregon) 1-800-452-0288.

If you have questions about this form, call the Workers' Compensation Division, Benefits Section, in Salem at 947-7585, (TTY: (503) 947-7993), or toll-free in Oregon: 1-800-452-0288.

EXHIBIT B - 2

OSHA Recordkeeping Guidelines

Recordable Cases

If you are subject to recordkeeping regulations, you are required to record information on OSHA Form 200 about: (1) every occupational fatality; (2) every nonfatal occupational illness; and (3) those nonfatal occupational injuries that involve one or more of the following: loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment other than first aid (see guidelines below).

Nature of injury	Medical treatment (recordable)	First aid (non-recordable)
Cuts, lacerations, punctures, abrasions, splinters	• Sutures (stitches). • Butterfly sutures. • Treatment of infection. • Application of antiseptic on second or subsequent visit to a doctor or nurse. • Removal of foreign bodies requiring skilled services of physician due to depth of embedment, size or shape of object(s), or location of wound.	• Bandaging on any visit to doctor or nurse • Application of antiseptic on first visit to doctor or nurse. • Application of ointments on first or subsequent visits to prevent drying or cracking of skin. • Removal of foreign bodies from wound by tweezers or other simple techniques. • Removal of foreign bodies in the eye, not embedded, by irrigation.
Fractures	• Where X-ray results are positive. Application of a cast or other professional means of immobilizing injured part.	• Where X-ray taken as a precaution is negative for fracture.
Strains, sprains, dislocations Any strain, sprain, or dislocation is recordable if the worker's range of motion is affected in a manner which prevents carrying on any of his or her regularly assigned duties, whether or not medical treatment is rendered.	• Application of a cast or other professional means of immobilizing injured part. • Use of hot or cold compresses for treatment of strains, sprains, and dislocation on second or subsequent visits to a doctor or nurse. • Use of diathermy and whirlpool treatments.	• Use of an elastic (Ace) bandage on a strain that is not otherwise recordable, on first visit to a doctor or nurse. • Use of hot or cold compresses for treatment of a strain on first visit to a doctor or nurse.
Thermal or chemical burns Any burn is recordable if the worker's range of motion is affected in a manner which prevents carrying on any of his or her regularly assigned duties, whether or not medical treatment is rendered.	• Treatment of all second and third degree burns.	• Treatment by a doctor or nurse for a first degree burn.
Bruises, contusions Any bruise or contusion is recordable if the worker's range of motion is affected in a manner which prevents carrying on any of his or her regularly assigned duties, whether or not medical treatment is rendered.	• Treatment of a bruise by draining collected blood. • Soaking or application of cold compresses to a bruise on second or subsequent visits to a doctor or nurse.	• Soaking or application of cold compresses to a bruise, that is otherwise not recordable, on first visit to a doctor or nurse.

Miscellaneous procedures

- Tetanus shots, either initial shots or boosters, are considered preventive in nature and are not considered medical treatment.
- An X-ray that is negative for fracture is not considered medical treatment.
- Hospitalization for observation, where no treatment is rendered other than first aid, is not considered medical treatment. However, most injuries requiring hospitalization will result in lost workdays and will be recordable for that reason.
- The observation of injury by a doctor or nurse on second or subsequent visits is not recordable.
- Using prescription drugs constitutes medical treatment. Recommending or giving nonprescription medicines is considered first aid.

OSHA recordkeeping questions may be referred to:

Department of Consumer & Business Services, Information Management Division
350 Winter St. NE, Room 21, Salem, OR 97310
Phone: (503) 378-8254 (V/TTY)

440-1314a (2/96/COM)

(2 part NCR)

SUPERVISOR'S VEHICLE ACCIDENT REPORT
SAFETY COMMITTEE REVIEW

INSTRUCTIONS: Supervisor is to complete this form and forward all copies to Personnel within 72 hours of knowledge of vehicle accident. Refer to Administrative Regulation No. 85-6, Safety and Health, XII, Vehicle Accidents. This report serves as the written narrative from the employee and supervisor describing the accident.

EMPLOYEE_____ CLASSIFICATION/TITLE_____

DEPARTMENT/DIVISION_____ SUPERVISOR_____

DATE OF ACCIDENT_____ TIME_____ ☐ AM ☐ PM DATE REPORTED_____ TIME_____ ☐ AM ☐ PM

LOCATION OF ACCIDENT_____

ACCIDENT INVOLVED: ☐ One other MV ☐ Bicycle/Tricycle ☐ Non-Collision ☐ Private Property
☐ Three or More MVs ☐ Pedestrian ☐ Animal ☐ Other_____
☐ Motorcycle/Moped ☐ Fixed Object ☐ Public Property

POLICE ACTION: Accident Report Filed ☐ Yes ☐ No Police Case No._____
Citation Issued ☐ Yes ☐ No If yes, name_____

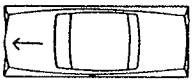
INJURY INVOLVED: Employee ☐ Yes ☐ No Other ☐ Yes ☐ No If yes, name_____
(Refer to Administrative Regulation No. 85-6 for occupational injury reporting procedures.)

ACCIDENT REPORTED TO CITY ATTORNEY: ☐ Yes ☐ No ☐ Not Applicable

DESCRIPTION: (Describe cause of accident, contributing factors, dollar estimate(s) of damage, etc.)

SKETCH OR PHOTOGRAPH OF ACCIDENT SCENE: (Indicate north on sketch by an arrow.)

DAMAGE: (Indicate where damage occurred to vehicle.)



REVIEW WITH EMPLOYEE: (Describe follow-up safety procedures, corrective action taken, and discussion with employee.)

Employee Date

Immediate Supervisor Date

Department Head Date

SAFETY COMMITTEE REVIEW: Accept Supervisor's Report: ☐ Yes ☐ No Citywide Impact: ☐ Yes ☐ No

Committee Recommendation:

Submitted by:

Chairperson Date

Reviewed by:

Safety Officer Date