Quick Guide
When Injured On the Job

What should I do when injured on the job?

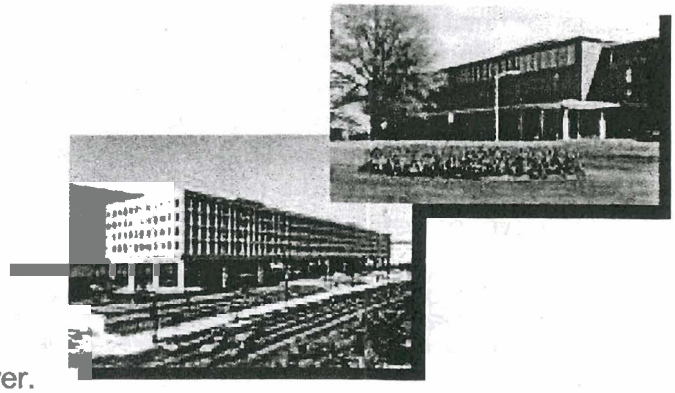
1. First and foremost, treat the injury. If you need medical attention, report to the Occupational Health Clinics: Forrestal, GG-028 and Germantown, A-075.
   For life-threatening emergencies,
   - **Call 166** (Forrestal, Germantown, 955 L'Enfant Plaza, or Cloverleaf Center IV)
   - **Call 9-911** (270 Corporate Center or 950 L'Enfant Plaza).
2. Inform your supervisor.
3. Complete DOE 5484.3 - Individual Accident/Incident Report.
4. Complete workers' compensation forms:
   CA-1 - Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay (COP).
   CA-2 - Federal Employee's Notice of Occupational Disease and Claim for Compensation.
   - CA-16 - Authorization for Examination and/or Treatment.

What types of injuries or illnesses are reportable?

Report all accidents, injuries, and illnesses that occur on DOE property, while on official government travel, and/or while performing work-related activities. These accidents/incidents include: slips, trips, or falls; back, shoulder, neck, or other muscle strains; exposure to chemical fumes or radiation; cuts, broken bones, or bruises; motor vehicle accidents; food poisoning; occupational illnesses including infectious diseases if exposed while at work or on official travel; and hospitalizations for work-related accident, injury, or illness. Report accidents even if they don't result in an injury.

Which forms do I need?

1. To report an accident or incident
   - DOE Form 5484.3
2. For workers' compensation for Federal employees
   - CA-1 for traumatic injury
   - CA-2 for an illness or exposure
   - CA-16 for medical treatment
3. For workers' compensation for contractors
   - Request appropriate State forms from your employer.



Where do I get the forms?

Accident/Incident Report:
HQ Safety & Health Office,
Forrestal GE-112, (202) 586-1005

Workers' Compensation Forms:
HQ Employee WorkLife Center,
Forrestal 4E-072, (202) 586-2452
Occupational Health Clinics
Forrestal, GG-028, Germantown, A-075

Who should complete the forms?

The injured employee should complete the necessary paperwork. If the employee is unable to do so, they may designate an individual to complete and file the forms for them.

Where do I submit paperwork?

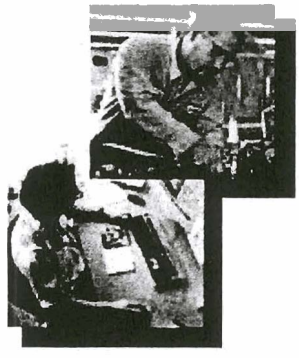
Accident/Injury reports, CA-1s and CA-2s, must be submitted through your supervisor to the following offices:

- Accident/Incident reports, including any witness statements, should be submitted to the Headquarters Safety and Health Office, Forrestal room GE-112, (202) 586-1005.
- Federal Worker Compensation (OWCP) forms and paperwork including medical bills and questions relating to OWCP, should be directed to the Headquarters Employee WorkLife Center at Forrestal room 4E-072, (202) 586-2452.
- Contractor Workers' Compensation forms must be submitted to their employer.

Who provides compensation?

The Department of Labor, Office of Workers' Compensation Program provides compensation benefits to Federal employees for disability due to personal injury sustained while in the performance of duty or due to employment-related disease. Benefits cannot be paid if the injury is caused by the willful misconduct of the employee, by the employee's intention to bring about his or her injury or that of another, or if intoxication (by alcohol or drugs) is the proximate cause of the injury. State laws govern workers' compensation benefits for contractors.

Will I automatically be compensated?



No, the Office of Workers' Compensation Program reviews all cases and determines eligibility for compensation.

What is Continuation of Pay (COP) and how is eligibility determined?

In traumatic injury cases **only, if the employee is unable to report to work,** Federal employees may be eligible for uninterrupted regular pay for up to 45 calendar days. To be eligible for COP, the employee, or someone acting on their behalf, must file the CA-1 within 30 days following the injury. They must also provide medical evidence in support of the disability within 10 days of submission of the CA-1. The Office of Workers' Compensation Programs will review the case information and determine eligibility. If the disability continues for more than 45 calendar days, compensation for lost wages may be payable after a three-day waiting period in a non-paid status. The injured employee also has the option of using sick or annual leave, or leave without pay. State laws govern COP for contractors.

What does a supervisor need to do?

Supervisors must review accident/incident reports as well as CA-1s and CA-2s. On each of these forms, there is a special section that must be completed by the supervisor after they have assessed the incident which resulted in the injury or illness. Based on this information, the supervisor determines if the injury resulted from a work-related activity, and if other factors contributed to the cause. It is incumbent upon a supervisor to take actions to prevent a recurrence of the injury or illness. The supervisor may request assistance from Program Office Safety and Health representatives to help identify corrective actions.

Where can I get more information?

HQ Office of Safety, Health and Security
Forrestal room GE-112, (202) 586-1005
http://www.administration.doe.gov - under Safety and Health Tab

HQ Employee WorkLife Center
Forrestal room 4E-072, (202) 586-2452
http://www.worklifecenter.doe.gov/

HQ 5484.3 Draft
All Other Editions
Are Obsolete

U.S. Department of Energy
ACCIDENT/INCIDENT REPORT
Official Use Only - Privacy Act

Information about the Employee

1) Full Name_____ **2) SSN/ID Number** |_|_|_|_|_|_|_|_|_|

3) Home Address (Street/City/State/Zip) _____

4) Date of Birth (MMDDYYYY) |_|_|_|_|_|_|_|_| **5) Gender:** [ ] Male [ ] Female

DOE Affiliation

6) DOE Affiliation: [ ] DOE Employee [ ] Contract employee [ ] Other Federal employee [ ] Visitor/Guest

7) Badge Number: |_|_|_|_|_|_|_|_| **8) Date of Hire/Service Comp Date** (MMDDYYYY) |_|_|_|_|_|_|_|_|

9) If contractor or other federal employee:

Name of employer:_____

Address of employer (Street/City/State/Zip):_____

Reason for work/affiliation: _____

10) Job Title _____ **11) Duty Station:** _____

12) Date started work at this location (MMDDYYYY) |_|_|_|_|_|_|_|_|

13) Organization Name _____ **14) Organization Code** _____

Information about the Case

15) Accident Type: [ ] Injury [ ] Property Damage [ ] Government vehicle [ ] Exposure to chemical/radiation [ ] No Injury
[ ] Skin Disorder [ ] Respiratory conditions [ ] Poisoning [ ] Hearing loss [ ] Other illnesses

16) Accident Place: [ ] Indoors [ ] Outdoors **17a) On DOE Property?** [ ] Yes [ ] No [ ] Unknown

17b) On your Employer's Premises? [ ] Yes [ ] No [ ] Unknown

18) Specific Location (include building): _____

19) Date of Injury or Illness (MMDDYYYY) |_|_|_|_|_|_|_|_| 20) **Time of event (military)** |_|_|_|_|

21) Time employee began work (military) on day of injury/illness |_|_|_|_|

22) What happened?

23) Was medical treatment sought? [ ] Yes, immediately [ ] Yes, but not immediately [ ] No

If Yes, where? [ ] Health Unit [ ] Emergency Room Visit [ ] Private physician [ ] Other

Name of physician or other heath care professional: _____

Treatment Facility Name:_____

Treatment Facility Address (Street/City/State/Zip):_____

24) Was employee hospitalized overnight as an in-patient? [ ] Yes [ ] No

25) Was time lost due to injury/illness? [ ] Yes [ ] No

26) Were others injured? [ ] Yes [ ] No If yes, specify names:_____

27) Name of Person Who Completed Form:_____ **Phone:** |_|_|_|-|_|_|_|-|_|_|_|_|

I affirm that the information submitted above is true and accurate to the best of my knowledge.

28) **Signature:** _____ **Date** (MMDDYYYY) |_|_|_|_|_|_|_|_|

Internal Use Only

Case Number: |_|_|_|_|_|_|

Multi-Case No. _____

Is the case closed? [ ] Yes [ ] No

Accident Investigation? [ ] A [ ] B [ ] C [ ] Internal [ ] None

Division/Dept Code |_|_|_|_|_|_|

Building: |_|_|_|_|_|_|

Organization Code |_|_|_|_|_|_|

OSHA Recordable? [ ] Yes [ ] No

Lost Work Days? [ ] Yes [ ] No

Days away from Work |_|_|_|_|_|

Days of job restriction/transfer |_|_|_|_|_|

Permanent Transfer due to injury? [ ] Yes [ ] No

Terminated due to injury? [ ] Yes [ ] No

Death due to injury? [ ] Yes [ ] No

Date of Death: |_|_|_|_|_|_|

Workers' Comp. Case Number |_|_|_|_|_|_|

Occupation Code: |_|_|_|_|_|

Individual Accident/Incident Report

Investigation

29) ACTIVITY: What was the employee doing just before the incident occurred? Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

29a) Experience on this job/equipment [ ] Under 3 months [ ] 3 to 12 months [ ] Over 12 months

30) EVENT: What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

31) NATURE of Injury/Illness: What was the injury or illness? Tell us the part of body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

32) OBJECT: What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, indicate "N/A".

33) PPE: What personal protective equipment was employee wearing? Examples: Hard hat, safety shoes, goggles, shields, aprons, gloves, respirators.

34) Did the employee die? [ ] Yes [ ] No
34a) If yes, enter date of death (MMDDYYYY) |__|__|__|__|__|__|__|__|

35) CAUSES: State the conditions that existed at the time of the event, the actions on the part of the employee that contributed to the incident, and the factors or underlying causes that contributed to the incident.

Conditions:

Actions:

Factors:

35-a) Direct cause _____ Indirect Cause_____

36) CORRECTIVE ACTIONS: Describe actions taken or recommended to prevent recurrence of the incident.

Actions Taken:

Actions Recommended:

Implementation date for recommended corrective actions (MMDDYYYY): |__|__|__|__|__|__|__|__|

I affirm that the information submitted above is true and accurate to the best of my knowledge.

37) Person Completing Form:_____

Title_____ **Phone:** |__|__|__|-|__|__|__|-|__|__|__|__|

Signature: _____ **Date** (MMDDYYYY) |__|__|__|__|__|__|__|__|

38) Employee's Supervisor: _____

Title_____ **Phone:** |__|__|__|-|__|__|__|-|__|__|__|__|

Signature: _____ **Date** (MMDDYYYY) |__|__|__|__|__|__|__|__|

Internal Use Only

Case Number: |__|__|__|__|__|__|

Activity code: |__|__|__|__|

Event code: |__|__|__|__|

Nature code: |__|__|__|__|

Part of body affected code: |__|__|__|__|

Primary object or substance |__|__|__|__|

Other objects or substances: |__|__|__|__|
|__|__|__|__|
|__|__|__|__|

PPE being worn: |__|__|__|__|
|__|__|__|__|
|__|__|__|__|

Equipment contributed to cause or severity?
[ ] Yes [ ] No