B-2. ACCIDENT REPORTING

I. SCOPE

These procedures are applicable to all employees of NCI-Frederick.

II. PURPOSE

A. To provide for the systematic reporting and investigation of occupational injury and illness or work conditions that caused or reasonably could result in injury, illness, or property damage. Reporting is mandatory in order that:

1. Extent of injury or illness may be determined and appropriate interventions initiated.

2. Cause(s) may be identified and, if appropriate, corrective action initiated to prevent a recurrence.

3. OSHA reporting and recordkeeping requirements can be met.

4. Workers compensation insurance notification requirements can be met.

III. DEFINITIONS

Accident - Is defined as an event occurring at work or while on company business that caused or reasonably could have caused injury or illness to personnel.

Near-Miss – Is defined as a potential hazard or incident that does not result in any personal injury, but has the potential to do so. For example, unsafe working conditions, unsafe employee work habits, improper use of equipment, or use of malfunctioning equipment have the potential to cause work related injuries.

Occupational illness - Is defined as any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. Occupational illnesses include acute and chronic illness or disease, which may be caused by inhalation, absorption, ingestion, injection, direct contact, or cumulative trauma.

Occupational injury - Is identified as any bodily damage such as a cut, fracture, sprain, strain, amputation, etc. which results from a single instantaneous exposure in the work environment.

IV. GENERAL PROCEDURES

A. All accidents, regardless of apparent degree of severity or whether employees are injured or not, (including near-misses), must be reported to the employee's supervisor and Occupational Health Services (OHS).

B. EHS/OHS shall be responsible for notifying the Principal Investigator, SAIC-Frederick, of all serious injuries or illnesses.

C. Forms used:

1. National Cancer Institute at Frederick Supervisor's Investigation of Injury/Illness, Exhibit B-2-1.

2. "Workers Compensation - First Report of Injury or Illness", form IA-1 (5/93), Exhibit B-2-2.

3. EHS Response Record, Exhibit B-2-3.

4. Accident investigation report generated by EHS.

V. RESPONSIBILITIES

A. Supervisor

1. Trains all employees in accident reporting requirements and reviews requirements annually with employees.

2. Ensures that employees report each occupational illness and injury, or near-miss to EHS/OHS.

3. Completes and submits the National Cancer Institute at Frederick Supervisor's Investigation of Injury/Illness form to EHS.

B. Employees

1. Report each occupational injury, illness, or near-miss to their supervisor immediately and notify EHS if hazardous conditions exist as a result of the incident.

2. Perform appropriate first aid measures at the scene of the accident as necessary.

3. Report to OHS if injured or ill (regardless of severity).

4. Give statement to OHS staff. Sign the "employee statement" section of the National Cancer Institute at Frederick Supervisor's Investigation of Injury/Illness form (Exhibit B-2-1).

5. Give signed National Cancer Institute at Frederick Supervisor's Investigation of Injury/Illness form to supervisor.

6. Cooperate with EHS accident/injury investigation, if applicable.

7. Participate in initial safety training orientation sessions and periodic safety training as required.

C. Environment, Health and Safety Program (EHS)

1. Responds to OHS for all reported occupational injuries and illnesses and completes the EHS Response Record.

2. Formally investigates all serious injuries and illnesses as soon as possible.

3. Reviews and investigates, as necessary, non-serious injuries, illnesses, near-misses, and potential exposures in accordance with internal SOPs and coordinates follow-up procedures with OHS.

4. Investigates root causes to determine actions required to preclude recurrence.

5. Enters accident investigation information in the Occupational Health Manager (OHM) computer software system.

6. Maintains a permanent file of completed Supervisor's Investigation of Injury/Illness forms (Exhibit B-2-1), EHS Response Records, and accident investigation reports.

7. Reports information on multiple injuries or death to OSHA officials as required by law.

8. Sends monthly summary report of departmental accidents to program Supervisors, Directors, or PI's as appropriate.

D. Occupational Health Services

1. Injured employees or visitors will receive priority evaluation, treatment and follow-up by OHS staff.

2. Initial interview to determine nature of injury and potential for hazardous exposure. (Refer to OHS operations manual).

3. OHS staff will notify EHS of accidents, initiating the EHS Response Record, and coordinate care based on information derived from the response and accident investigation.

4. In the event of serious injury, local community emergency response or referral procedures will be initiated. (Refer to B-1 Emergency Response Procedures.)

5. Completes and forwards to worker's compensation insurance carrier an Employer's First Report of Occupational Injury or Illness within 24 hours of first knowledge of an occupational injury or illness that requires medical treatment.

6. Maintains a copy of the first report of injury in the employee's medical record.

7. Updates the OSHA log regularly, regarding the number of days of lost time and restricted duty as required by 29 CFR 1904 and communicates this info as necessary.

8. Posts OSHA Form 300A, Summary of Work-related Injuries & Illnesses.

National Cancer Institute at Frederick
Environment, Health and Safety Program
P.O. Box B, Building 426, Fort Detrick USAG
Frederick, Maryland 21702

Supervisor's Investigation of Injury/Illness

LOG CASE No: _____

EMPLOYEE, SAMPLE	**123-45-6789**		
Employee Name	SSN	Department	Job Title
Company	Employee's Supervisor	Supervisor's Phone #	Date & Time Reported to Supervisor
Bldg. - Loc. Of Accident (Be Specific)	Date/Time Occurred	Nature of Injury/Illness	Specific Body Part

Witness

Employee's Statement(s):

" "

Employee Signature	Date Signed

Does your investigation concur with the employee's statement? List discrepancies and other missing information.

(use additional pages if necessary)

1. Was required personal protective equipment utilized? ☐ Yes ☐ No
2. Were safety rules violated? ☐ Yes ☐ No
3. Was discipline issued related to safety? ☐ Yes ☐ No To Whom? _____
4. Was use of power tool or machinery a factor in the injury? ☐ Yes ☐ No
   If yes, identify: _____ Mfg Name: _____
5. Have there been similar injuries to other employees on the same job? ☐ Yes ☐ No
   If yes, identify other employees by name and SSN: _____
6. Did employee return to his/her regular job? ☐ Yes ☐ No
7. Was employee temporarily transferred because of restriction assigned? ☐ Yes ☐ No
8. Was the employee unable to work because of lack of available and suitable work? ☐ Yes ☐ No

Action and preventive measures by supervisor to prevent recurrence of similar event:

(use additional pages if needed)

Is assistance needed from Maintenance or other departments to correct an unacceptable condition? ☐ Yes ☐ No
If yes, who was notified? _____ Dept _____
Date & Time _____

(COMPLETE REVERSE SIDE OF THIS FORM AS APPROPRIATE)

UPON COMPLETION OF ALL APPLICABLE SECTIONS,
SIGN AND RETURN FORM TO EHS SECRETARY, BLDG. 426, ROOM 118

NOISE:

1. Date assigned into high noise area: _____
2. Employee's current noise level exposure _____ dBA
3. Type of hearing protection worn: _____
4. Date of last employee training: _____
5. Are regular documented hearing protection audits of this department performed? ☐ Yes ☐ No
6. Has employee been wearing hearing protection properly? ☐ Yes ☐ No

TEMPERATURE/RADIATION:

1. Was cold temperature involved in illness? ☐ Yes ☐ No
2. Was illness related to heat stress? ☐ Yes ☐ No
   If yes, was incident: ☐ Heat Stroke ☐ Heat Exhaustion
   ☐ Heat Rash ☐ Heat Cramps ☐ Other _____
3. What was heat stress index at time of incident? _____
4. What type of radiation was involved? ☐ Microwave ☐ Radio Frequency ☐ Ultra Violet
   ☐ Visible ☐ Lasers ☐ Beta, Gamma, X-Rays

REPETITIVE MOTION:

1. What body part was affected? _____
2. What was position of body part? _____
3. How often was position or action repeated each cycle? _____
4. How forceful was this action?(Light, Medium, Heavy) _____
5. Hours worked by employee per week _____
6. Current production or job rate per minute _____
7. Length of time on job causing condition? _____
8. Was vibrating tool used? ☐ Yes ☐ No
9. Was air temperature less than 50 F/10 C? ☐ Yes ☐ No

CHEMICAL:

1. Was chemical an approved material? ☐ Yes ☐ No
2. Part # _____ Supplier Code: _____
   Description: _____ Chemical Name: _____
5. How long has employee used chemical? _____
6. Date last trained? _____ By Whom? _____
7. Were other chemicals involved? ☐ Yes ☐ No
8. List them:

BIOLOGICAL:

1. Exposure Type: _____
2. Exposure Fluid: _____
3. Exposure Route: _____
4. What procedure was involved? _____
5. When did exposure occur? _____

6a. Item Involved: _____ 6b. Item had a safety design? ☐ Yes ☐ No

7. Was the item contaminated? _____
8. What was the item's original purpose? _____

Supervisor's Name (Please Print): _____
I.D.No. _____

Supervisor's Signature: _____ Date _____

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)
SAIC-Frederick, Inc.
P.O. Box B
Frederick MD 21702

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

TELEPHONE (INCLUDE AREA CODE)

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE

PER:
☐ DAY
☐ WEEK
☐ MONTH
☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED>24 HRS
☐ FUTURE MAJOR MEDICAL /LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

FORM IA-1 (5/93)

SEE BACK FOR IMPORTANT INFORMATION/OSHA REQUIREMENTS

IAIABC 1993
WCER3N.1

NOTICE

This form is NOT a claim for compensation. Failure to file a claim within 2 years of the date of accidental injury may bar an employee's claim for compensation. Employees may obtain claim forms from the Workers' Compensation Commission.

EMPLOYER:

COMPLETE BOTH SIDES OF THIS FORM AND SEND IT IMMEDIATELY - -

WORKERS' COMPENSATION COMMISSION
6 NORTH LIBERTY STREET, BALTIMORE, MARYLAND 21201-3785

A copy of this form must be mailed to the DIVISION OF LABOR AND INDUSTRY, 501 ST. PAUL PLACE, BALTIMORE, MARYLAND 21202 and an additional copy should be sent by the employer to his or her workers' compensation insurance carrier. The weekly earnings schedule below of the employee whose injury is being reported on the front side of this form should be completed at the time the report is submitted if at all possible, but in any event the wage information must be supplied no later than ten (10) days following the the employer's receipt of a Notice of Claim from the Commission. An employer's failure to submit the wage information as required will result in the Commission's use of information supplied by the Claimant to the possible detriment of the employer.

REPORT OF WAGE INFORMATION

MILDRED R FLEMMING — Injured Employee Name

216-54-4915 — Social Security Number

Week No.	Week Ending Month Day Year	Days Worked	GROSS Amount Paid Including all Overtime
1		0	0.00
2		0	0.00
3		0	0.00
4		0	0.00
5		0	0.00
6		0	0.00
7		0	0.00
8		0	0.00
9		0	0.00
10		0	0.00
11		0	0.00
12		0	0.00
13		0	0.00

Was this employee given free rent, lodging, board, tips or other allowances in addition to the above earnings? If yes, state weekly value thereof. $_____

Signed _____

(MD Supp Rev 11/90)