ALBANY COUNTY FIRE DISTRICT #1

On-Duty Injury and Exposure Reporting Policy

Approved on ??/??/?? by Luke Hawkins, Brett Wadsworth, Matt Burkhart

Purpose: Ensure that all Albany County Fire District (ACFD) related incidents are promptly reported, recorded, and, if necessary, investigated.

General: To outline the procedures for reporting ACFD-related injuries, illnesses, accidents, exposures, and other incidents that occur on duty, so proper medical attention may be provided. The scope of the policy typically applies to all ACFD employees and volunteers.

All reports are considered confidential, non-punitive and non-retaliatory. Information regarding personal injury, illness or exposure is considered private and shall only be shared to the extent allowable by law. Incidents that are the result of policy or procedure violations may be investigated and disciplinary action or non-coverage may result where the person is found at fault.

On-Duty Injury Reporting

A) All on-duty injuries and/or exposures shall be reported immediately to the injured member's department Fire Chief. On-duty injuries are defined as injuries which were incurred while serving Albany County Fire District in a volunteer or employment capacity, as described in the employee or volunteers job description.

B) The injured employee/volunteer is responsible for all required reporting of the injury.

C) When an injury occurs, for which the individual will not seek medical attention or other Workers' Compensation benefits, a "Non-Treated Injury Report Form" shall be completed. The form shall be delivered to the employee's/volunteer's department Chief within 24 hours. The Fire Chief and a District Coordinator shall sign the form and deliver it to the ACFD Administrative Assistant to be filed.

D) If it is reasonably suspected that an injury will require medical attention, the employee/ volunteer shall complete the following:

1. The "Wyoming Report of Injury" contained within the packet shall be delivered to the employee's/volunteer's department Chief no later than 72 hours after the injury. The Chief shall sign the form and deliver it to the ACFD #1 Human Resources to be filed with Wyoming Worker's Compensation. ~~If Human Resources is not available, the packet should be delivered to the Fire District Coordinator.~~ (https://dws.wyo.gov/dws-division/workers-compensation/forms-documents/)

2. The "ACFD #1 Incident/Accident/ Near Miss Report" must be completed and routed according to the instructions contained on the report form.

E) If an injury occurs during response or operations, at a fire incident, the Officer or Chief reporting the incident shall include a Firefighter Casualty Report with his/ her incident report.

F) If an employee/ volunteer obtains medical attention for an on-duty injury or exposure, the employee/ volunteer cannot return to service in any capacity without a work release

specifying limitations. The work release must be signed by the employee's/ volunteer's medical provider and submitted to the department Chief.

Exposure Reporting

Any individual who is, or is suspected to have been, exposed to a contagious disease while in the course of performing their assigned duties will:

3. Immediately report the exposure to their department's Chief. If unable to contact the department's Chief, the injury must be reported to a Department Officer.

4. Fill out and submit documentation required for an on-duty injury.

5. Be afforded the opportunity to self-transport or be driven to closest hospital, or appropriate medical facility, for evaluation and consultation with a Physician regarding potential courses of treatment, if indicated.

Near-Miss Reporting

An individual who is part of or has been witness to a Near-Miss is encouraged to file a "Near Miss Report" with the Department Chief, who will ensure a copy is made available to the District.

A near-miss event is defined as an opportunity to improve health and safety practices based on a condition or an incident with potential for more serious consequence. These reports will be used for training and evaluation of protocol and policy to help improve safety.

HR Reviewed: November 2023

Department of Workforce Services
Division of Workers' Compensation
Report of Injury

EMPLOYER INFORMATION

Please use **BLACK** ink. Do not cross zeros or sevens

Claim Number: _____

BUSINESS NAME			WORK COMP EMPLOYER #
ADDRESS			
CITY	STATE	ZIP	PHONE
TAX ID TYPE (FEIN OR SSN)	TAX ID NUMBER		NATURE OF BUSINESS (MANUFACTURING, ETC.)

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI
MAILING ADDRESS	CITY / STATE / ZIP	
PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING ADDRESS	CITY / STATE / ZIP	
PHONE (WITH AREA CODE)	EMAIL ADDRESS	
DATE OF BIRTH	DATE OF HIRE	STATE OF HIRE
SOCIAL SECURITY NUMBER	US CITIZEN? ☐ YES ☐ NO	IF NO, PROVIDE INS#
SEX ☐ FEMALE ☐ MALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	

INJURY INFORMATION

DATE OF INJURY	TIME OF INJURY ☐ AM ☐ PM	TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	TIME EMPLOYEE ENDED WORK ☐ AM ☐ PM
DATE EMPLOYER WAS NOTIFIED OF INJURY	LAST DAY OF WORK AFTER INJURY	DATE OF RETURN TO WORK	EMPLOYEES OCCUPATION (JOB TITLE) WHEN INJURED
TYPE OF EMPLOYEE ☐ REGULAR ☐ VOLUNTEER ☐ INMATE ☐ OTHER		EMPLOYEE STATUS ☐ OWNER ☐ PARTNER ☐ CORPORATE OFFICER ☐ INDEPENDENT CONTRACTOR	
NAME OF PERSON CONTACTED		CONTACT PHONE NUMBER	DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO
ADDRESS OR LOCATION OF ACCIDENT	CITY	COUNTY	STATE / ZIP
FATALITY ☐ YES ☐ NO	IF YES, WHAT IS THE DATE OF DEATH?	DID INJURY RESULT IN MEDICAL TREATMENT OR LOST TIME FROM WORK? ☐ MEDICAL TREATMENT ☐ LOST TIME FROM WORK	
NAME OF PHYSICIAN OR HEALTH CARE PROFESSIONAL	ADDRESS / CITY / STATE / ZIP CODE		DATE OF INITIAL EXAM

LIST ALL BODY PARTS AND LOCATION OF INJURY (SIDE OF BODY: RIGHT, LEFT, BI-LATERAL, MIDDLE, LOWER, UPPER OR UNKNOWN)

PRIMARY BODY PART:	SIDE OF BODY:	
HAS THIS BODY PART BEEN PREVIOUSLY INJURED? ☐ YES ☐ NO	IF YES, PLEASE EXPLAIN	
WAS PRIOR INJURY WORKERS COMP? ☐ YES ☐ NO	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?
SECONDARY BODY PART:	SIDE OF BODY:	
HAS THIS BODY PART BEEN PREVIOUSLY INJURED? ☐ YES ☐ NO	IF YES, PLEASE EXPLAIN	
WAS PRIOR INJURY WORKERS COMP? ☐ YES ☐ NO	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?

LIST ADDITIONAL BODY PARTS AND LOCATIONS BELOW:

BODY PART:	SIDE OF BODY:
BODY PART:	SIDE OF BODY:
BODY PART:	SIDE OF BODY:

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IMPORTANT: PLEASE COMPLETE THE BACKSIDE OF THIS FORM

Claim Number: _____

JOB DESCRIPTION

INJURED WORKER'S DETAILED JOB TITLE AT TIME OF INJURY. (For example: Civil Engineer, not just Engineer; RN or LPN, not just Nurse; Custodian or General Repairs, not just Maintenance)

WHAT WERE THE TYPICAL DUTIES OF THE INJURED WORKER'S JOB AT THE TIME OF INJURY? (For example: operating heavy equipment, mopping floor, hanging drywall, welding, doing data entry)

CAUSE OF ACCIDENT

WHAT HAPPENED? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, employee fell 20 feet:; "Employee was sprayed with chlorine when gasket broke during replacement".

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? Examples: "concrete floor"; "chlorine", "radial arm saw". If this question does not apply to the incident, leave it blank.

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 aladder while carrying roofing material", "spraying chlorine from hand sprayer", "daily computer key-entry".

WAGE INFORMATION

EMPLOYEE PAID ☐ HOUR ☐ DAY ☐ WEEK ☐ MONTH ☐ YEAR ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ OTHER		**IF HOURLY, WHAT IS THE RATE PER HOUR?**
IF NOT PAID HOURLY, WHAT IS THE EMPLOYEE'S PAY RATE	**HOURS WORKED PER DAY**	**NUMBER OF DAYS WORKED PER WEEK**
IS EMPLOYEE AUTHORIZED OVERTIME? ☐ YES ☐ NO	**NUMBER OF OVERTIME HOURS WORKED**	**EMPLOYEE PAID FOR THE DATE OF ACCIDENT?** ☐ YES ☐ NO
DOES THE EMPLOYEE HAVE MORE THAN ONE JOB? IF SO, STATE NAME OF EMPLOYER		**PROVIDE PHONE NUMBER OF THE ADDITIONAL EMPLOYER**

Employee Release: I authorize the Division of Workers' Compensation to disclose and or obtain information about my case to or from other state agencies, insurers, group health plans, third party administrators, health maintenance organizations or Medicare and Medicaid service centers, and any of my treating health care providers including pharmaceutical providers, past or present. The information that may be released or obtained includes: my name, my social security number, the medical services I received and the dates of those services, the amounts charged by health care providers for my medical services, and the amount of benefits paid. This information may be needed to ensure that benefit payment are not duplicated. The information given by me herein is true and correct. I agree this release shall remain in full effect until revoked by me in writing. Photocopies of this authorization shall be given the same effect as the original. I further acknowledge that misrepresentation or fraud can lead to a civil action and/or criminal prosecution.

EMPLOYEE SIGNATURE OR EMPLOYEE'S REPRESENTATIVE _____ TODAY'S DATE _____ RELATIONSHIP TO EMPLOYEE _____

PRINT EMPLOYEE OR REPRESENTATIVE NAME _____ EMPLOYEE SSN# _____

If you are a Medicare Beneficiary, you are required to provide your HICN or MBI assigned by the Social Security Administration: _____

Employer Certification: I am an authorized agent of the employer. The information given by me herein is true and correct. I further acknowledge that misrepresentation or fraud can lead to a civil action or criminal prosecution.

Do you believe this injury or condition is work-related? ☐ Yes ☐ No ☐ Unsure If No, please attach a letter of explanation stating the disputed facts.

Drug or alcohol test performed on date of injury? ☐ Yes ☐ No

EMPLOYER / SUPERVISORY SIGNATURE _____ DATE _____

PRINT EMPLOYER / SUPERVISOR NAME _____ TITLE _____

WORK COMP EMPLOYER # _____ BUSINESS NAME _____ PHONE #: _____

MAIL ORIGINAL TO:
Division of Workers' Compensation
PO Box 20207
Cheyenne, WY 82003-7005

EMAIL TO:
dws-wcintake@wyo.gov

IMPORTANT: For General information
visit dws.wyo.gov
Phone (307) 777-7441
Fax (307) 777-6552

DO NOT WRITE IN THIS AREA

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