INSTRUCTIONS FOR HANDLING WORK RELATED INJURIES

Purpose:

1. Ensure prompt assessment, response and care for employees involved in an incident resulting in an injury.
2. Inform employees that they have a right to report work-related injuries & illnesses and encourage them to do so.
3. Assure our employees that the YMCA of the Fox Cities will not discriminate against nor retaliate against them for making such reports.
4. Accurately document events, identify staff response and provide accurate, timely information for our workers compensation carrier.
5. Identify contributing factors/conditions that led to the incident and to identify steps to be taken to prevent the recurrence of a similar incident.

When an employee is injured during work, he/she is required to report this to their supervisor. Employees must complete an Employee Report of Injury Report form, which must be forwarded to their supervisor and Human Resources, as soon as, possible. **Serious injuries must be reported within the timeframe we are required to report them to OSHA. If an employee passes away it must be reported to OSHA within 8 hours and if an employee suffers an amputation, loss of an eye or is hospitalized it must be reported within 24 hours to OSHA.** If the work related injury or illness needs medical treatment beyond the first aid we can provide on-site, the employee can see their doctor, or any other health care provider. If an employee needs to seek outside medical treatment, the employee's supervisor needs to report this injury, as soon as, possible to Human Resources.

After a work related injury occurs, the employee who is ill or injured, their supervisor and the Human Resources Department have the following responsibilities:

Employee Responsibilities:

1. **Treat injury using first aid.**
2. **Report the injury** - The employee must report the work related injury/illness to their supervisor or the manager on duty and **complete an Employee Injury Report form,** including as much detail as possible, describing **How, Where, Why** and **When** the work related injury or illness occurred.
3. **If needed, seek medical attention** - Injured employees should consider seeking medical attention if they are unable to continue their shift.
4. **If medical treatment is sought from a doctor, get a return-to-work slip.** Return-to-work slips should be given to the employee's supervisor before returning to work. Return-to-work slips must also be turned in to the employee's supervisor after each follow-up doctor's appointment if continued treatment is required.

Supervisor Responsibilities:

1. **Provide first aid to the injured employee.**
2. **Complete the Employee Report of Injury form.** Ensure there is a detailed description of How, Where, Why and When the work related injury occurred on the Employee Report of Injury form. **Fax the completed form to Human Resources at 882-5019** & follow-up to ensure the form was received. Give a copy to the Branch Executive. **If the employee passes away, is hospitalized or suffers an amputation or loss of an eye, the injury must be reported within 8-24 hours. Please contact the HR Director in these situations.**
3. **Explain the entire process to the employee.**
    a. Complete Employee Report of Injury form and fax it to HR at 882-5019.
    b. Gather information from the employee on how this injury could have been prevented.
    c. Inform the employee that the HR department calls to check on injured employees and get details about injury and incident, plus reports the injury to our workers compensation carrier – United Heartland.
    d. Notify the employee that United Heartland may call the injured employee to get details.
    e. Remind the employee that they must get a return-to-work slip & give it to their supervisor if they receive medical treatment and ask them to keep in contact with their supervisor and Human Resources.
    f. Follow any and all restrictions stated on the employee's return-to-work slip and if needed, Human Resources, and the employee's supervisor will work together to provide light duty work.
4. **Obtain a return-to-work slip from employees who seek medical treatment before they return to work** and after each follow-up visit. Send the original return-to-work slip to Human Resources immediately.
5. **Investigate the injury thoroughly, and provide Human Resources with details.**
6. **Determine action steps to prevent this type of injury/incident from reoccurring and ensure the actions steps are implemented.**
7. **Assist employees with restrictions in returning to work safely in a modified capacity.** Contact Human Resources for support and if light duty work is needed.

Human Resources Responsibilities:

1. After receiving the Employee Report of Injury form - **Contact the employee to see how they are doing, get details of incident/injury and discuss the employee's treatment plan and restrictions if necessary.**
2. **Complete on-line report for United Heartland, our worker's compensation carrier.**
3. **Communicate with supervisor and/or branch to determine what action needs to be taken to prevent injury from re-occurring.** Discuss employee's return to work if there are any restrictions and determine how we can accommodate these restrictions while getting the employee back to work safely.

YMCA of the Fox Cities Employee Report of Injury

First Name_____ **Last Name** _____

Address_____ **City**_____ **State**_____ **Zip**_____

Phone (___) ____-_____ Birth Date___/___/_____ Job Title_____

Branch #_____ Dept #_____ Date of Injury ____/____ /_____ Time of Injury _____ ☐ AM ☐ PM

Date Employer Notified___/____ /_____ Employee's Scheduled Shift (when injured): _____

Location injury occurred at: ☐ Corporate Office ☐ Appleton YMCA ☐ Apple Creek YMCA ☐ Camp NABS
☐ Child Learning Center ☐ Fox West YMCA ☐ Heart of the Valley YMCA ☐ Neenah-Menasha YMCA ☐ Other

If OTHER is checked, please list address:_____

Where, exactly, did the injury occur on the premises:_____

Were there any witnesses? ☐ Yes ☐ No **If YES, list name(s) & contact information:**_____

_____

Did the injury cause death: ☐ Yes ☐ No **If YES, when did death occur: ___/___/_____**

Described how the injury occurred addressing the following:

1) What task was being performed at the time of injury:_____

_____

2) What happened to cause this injury, describe how the injury occurred:_____

_____

3) What equipment, objects, machinery, tools, etc. were involved:_____

_____

Cause of Injury - Check all that apply:

☐ Allergic Reaction	☐ Bitten by Animal/Human/Insect	☐ Caught In/Between Objects	☐ Cut/Puncture/Scrape	☐ Electrical Current
☐ Exposure-Bodily Fluids	☐ Exposure-Chemicals	☐ Fall -Same Level	☐ Fall -Different Level	☐ Fall –Snow/Ice
☐ Foreign Body in Eye	☐Holding/Carrying	☐ Jumping	☐ Lifting/Lowering	☐ Motorized Unlicensed Vehicle
☐ Motor Vehicle	☐ Pushing/Pulling	☐ Reaching/Bending	☐ Repetitive Motion	☐ Struck By/Against Object
☐ Struck by Human	☐ Temperature Extremes	☐ Using Tool/Machine	☐ Walking/Running	☐ Other

If **OTHER** is checked, explanation needed:_____

Affected Body Part(s) - Check all that apply and circle side that was affected (Right, Left or Both):

Head	Lower Extremities	Multiple Body Parts	Neck	Trunk	Upper Extremities
☐ Brain	☐ Ankle - R L B	☐ Artificial appliance	☐ Disc (neck)	☐ Abdomen ☐Spinal Cord	☐ Elbow - R L B
☐ Ear(s) - R L B	☐ Foot - R L B	☐ Body Systems	☐ Larynx	☐ Buttocks ☐ Stomach	☐ Finger(s) - T I M R P
☐ Eye(s) - R L B	☐ Great toe - R L B	(with no external injury)	☐ Multiple injuries	☐ Chest ☐ Upper back	☐ Hand - R L B
☐ Facial bones	☐ Hip	☐ Multiple body parts	☐ Soft tissue (neck)	☐ Disc (back) ☐ Vertebrae	☐ Lower arm - R L B
☐ Mouth	☐ Knee - R L B	☐ No physical injury	☐ Spinal Cord (neck)	☐ Heart ☐ Other	☐ Multiple injuries
☐ Multiple injuries	☐ Lower leg - R L B	☐ Unclassified	☐ Trachea	☐ Lower back	☐ Shoulder(s) - R L B
☐ Nose	☐ Multiple injuries	(insufficient info to	☐ Vertebrae	☐Lungs	☐ Thumb - R L B
☐ Skull	☐ Toes - T I M R P	properly identify)	☐ Other	☐ Multiple injuries	☐ Upper arm - R L B
☐ Soft Tissue	☐ Upper leg - R L B	☐ Other		☐ Pelvis	☐ Wrist - R L B
☐ Teeth	☐ Other			☐ Ribs	☐ Wrist(s) & Hand(s) - R L B
☐ Other				☐ Sacrum/coccyx	☐ Other

If OTHER is checked, explanation needed:_____

What type of injury: ☐ Strain ☐ Sprain ☐Cut ☐ Contusion/Bruise ☐ Broken bone ☐ Concussion ☐ Other

If OTHER is checked, explanation needed:_____

What type of treatment was given or will be given for your injury:
☐ No Treatment Necessary ☐ First Aid ☐ Medical Treatment (By Doctor) ☐ Undecided-May seek Medical Treatment

If **FIRST AID** is checked, described First Aid received:_____

Doctor First Name_____ Doctor Last Name_____

Clinic/Hospital Name _____ Phone Number (_____) _____-_____

Clinic/Hospital Address _____

How was the employee treated at Clinic/Hospital: ☐ Office Visit ☐ Emergency Room ☐ Hospitalized/Inpatient

Employee Signature_____ Date_____

Coordinator/Director/Executive/MOD_____ Date_____