Administrative Policy Manual

Policy No: A-29

Date: 11-6-2012

Approved: Dan Martinez

SUBJECT: Injury and Illness Prevention Program (IIPP).

PURPOSE: To provide guidelines and procedures for the establishment and maintenance of an on-going Injury and Illness Prevention Program throughout City of Indio Departments.

SCOPE: All City employees.

REFERENCES: California Code of Regulations, Title 8, General Industry Safety Orders Section 3203.

California Code of Regulations, Title 8, Construction Safety Orders Section 1509 California Labor Code.

I. GENERAL OVERVIEW

The above listed sections of the California Code of Regulations require every employer to establish and maintain an effective Injury and Illness Prevention Program (IIPP). Appropriate records shall be maintained of steps taken to implement and maintain programs. The program shall be in writing and shall contain, at a minimum, the following elements:

A. Who is responsible for implementing this program, and the methods for ensuring that all employees comply with safe and healthy work practices.

B. Include procedures for identifying and evaluating workplace hazards. Inspections shall be made to identify and evaluate hazards: whenever new substances, processes, procedures or equipment are introduced that present new occupational safety and health hazards, and whenever the employer is made aware of a new or previously unrecognized hazard. This includes periodic inspections to identify unsafe conditions and work practices.

C. Methods and procedures for correcting unsafe or unhealthy work practices in a timely manner.

D. Instructing employees in general safe and healthful work practices and to provide instructions with respect to hazards specific to each employee's job assignment.

E. A system for communicating with employees in a form readily understandable by all affected employees on occupational health and safety matters, including provisions designed to encourage employees to inform the City of Indio of hazards at the work site without fear of reprisal. Substantial compliance with this provision includes meetings, training programs, postings, written communications, a system of anonymous notification by employees about hazards, labor/management safety and health committees, or any other means that ensures communication with employees.

F. A system to ensure that employees comply with safe and healthy work practices. Substantial compliance includes recognition of employees who follow safe and healthful work practices, training and re-training programs, disciplinary actions or any other such means that ensures employee compliance.

G. An accident and incident investigation program must be implemented and maintained. Supervisory personnel must promptly investigate all work-related accidents, incidents, and near miss occurrences.

II. RESPONSIBILITIES

The City Manager is responsible for overseeing the IIPP for City Employees. The City Manager has designated the **Human Resources Manager** to direct the IIPP administration. The responsibility for implementing this program is hereby delegated to each Department Manager and shall be delineated in each Department's IIPP.

The Human Resources Manager or their designee shall coordinate the IIPP throughout the City. The **Human Resources Manager** or their designee shall have the following responsibilities:

A. Direct the IIPP throughout the City.

B. Oversee the IIPP throughout City operations to ensure compliance.

C. Monitor and report compliance and effectiveness of safety programs.

D. Inform Department Managers when corrective action is required.

E. Prepare and conduct educational programs in Safety and Health and Environmental Compliance.

F. Advise and assist all Departments in the development of safe operating practices and in the elimination of unsafe conditions.

G. Review and analyze all work injury and motor vehicle accident reports.

H. Investigate or assist in investigating all accidents that involve serious injury, death or whenever deemed necessary.

I. Inspect City property and make recommendations for the correction of unsafe work practices, procedures and unsafe physical or mechanical conditions of City property and facilities.

J. Communicate with the Departments regarding results of inspections and accident investigations.

K. Assist departments in identifying safety and accident prevention training needs. Coordinate training needs and schedules as appropriate for First Aid, Defensive Driving, RMI Principles, Supervisor Training and other accident prevention program training.

Department Managers are responsible for implementing the IIPP and the method for ensuring that employees comply with safe and healthful work practices within their areas of responsibility.

Public Works and Indio Water Authority should have as a policy, a written Safety Program, as required by State Law, to supplement the existing IIPP Policy. This policy shall identify the person or persons with authority and responsibility for implementing the program. The written program shall also identify the hazards unique to the Department, how they will be dealt with and outline any required training necessary to eliminate, reduce or control them. The Department Manager shall have the following responsibilities:

A. Identify unsafe and unhealthy conditions and work practices through safety and health inspections.

B. Correct hazards after identification.

C. Develop work procedures that minimize hazards to employees and to the public.

D. Assure that each employee receives adequate safety training in the tasks they are to perform, including any retraining of an employee when tasks have not been done to standard.

E. Use established procedures for disciplinary action to ensure that employees comply with safety and health regulations and work practices. Disciplinary action may include oral or written reprimand, suspension, demotion, and/or termination.

F. Establish a communications system to keep employees informed of safety and health regulations, and to allow employees to make complaints and receive a response to that complaint, without fear of reprisal.

G. Develop and maintain an Emergency Action Plan, to include evacuation assignments and routes.

H. Appoint at least one permanent department Safety Representative (DSR). One DSR per 200 employees is recommended, or one per facility.

I. Establish a means for making their departments more effective for the safety and health of their employees.

The Supervisor shall have the following responsibilities.

A. Encourage proper attitudes toward safety and job performance in their subordinates.

B. Recognize the potential for hazards of each job supervised, by conducting a job safety analysis.

C. Continuously observe and evaluate work conditions and procedures to detect and correct unsafe conditions and practices.

D. Enforce all safety rules, procedures, and policies. Where necessary, apply progressive discipline to employees who do fail to comply with safety rules, procedures, and policies.

E. Provide employee orientation and safety training in tailgate sessions.

F. Promptly investigate injuries and accidents to determine cause and to prevent recurrence.

G. Encourage employees to report unsafe conditions and to submit practical suggestions for correction.

H. Ensure that tools, equipment and protective devices are properly maintained and utilized.

I. Attend Safety Orientation for Managers/Supervisors upon assumption of supervisory responsibilities.

The Employee should work in a safe and efficient manner at all times. The employee shall have the following responsibilities:

A. Maintain a neat, clean work area, free of hazards.

B. Report to supervision any hazard that could result in injury or illness to co-workers or the public.

C. Wear personal protective equipment as required.

D. Comply with established occupational safety and health laws.

E. Report all injuries to supervision.

F. Attend all required Safety Training.

III. HAZARD ASSESSMENT

A. Each Department Manager shall ensure safety and health inspections are conducted in all work areas for which they are responsible. Inspections shall be made to identify and evaluate hazards.

B. Whenever a Cal/OSHA Compliance Officer arrives at a City work site to conduct an inspection or investigation, the Human Resources Manager ***MUST*** be immediately notified.

IV. CORRECTING UNSAFE/UNHEALTHFUL CONDITIONS

A. Unsafe and unhealthy conditions shall be corrected in an expeditious manner. When an unsafe or unhealthy condition is identified, the Department Manager is responsible for ensuring corrective action is initiated.

B. When a serious or imminent hazard is found, the employees must be protected against this hazard until it is corrected. This could include shutting the job down until the hazard has been corrected or eliminated, or relocating employees to an alternate safe worksite.

V. EMPLOYEE TRAINING

Each Department shall develop a training program to ensure that its employees receive adequate safety and health training. Supervisors shall be knowledgeable and able to recognize the safety and health hazards to which employees under their immediate direction and control may be exposed. Each employee shall receive training as follows:

A. General safe and healthy work practices as well as specific instruction for hazards unique to the employees job assignment annually.

B. Before going on the job – whether the employee is a new hire, a transfer or receiving a new job assignment. Employees who receive a new job assignment, but are performing the same tasks, do not need to be retrained.

C. When a new substance, process, procedure or equipment that represents a new hazard is introduced to the workplace.

D. When the department receives notification of a new or previously unrecognized hazard.

E. When an employee experiences a preventable motor vehicle accident, he or she shall be scheduled for Driver Awareness training.

VI. COMMUNICATION

A. Departments must communicate safe work practice rules and other information relating to occupational hazards in an understandable manner, and make every effort to encourage employees to inform management about workplace hazards, free from fear of reprisal or other concerns.

B. Each department shall establish a means for its management to communicate its method for ensuring compliance with safe work practices, which should include disciplinary actions for non-adherence.

C. Safety and health bulletin boards should be established in each facility. When a department has various work areas, each area should maintain a safety and health bulletin board. This board should contain the Cal/OSHA poster along with the Workers' Compensation poster, Cal/OSHA Annual Year End Injury & Illness Summary Report, posted February 1 through April 30, safety bulletins, procedures for filing safety and health complaints, and any other information to communicate with employees concerning safety and health.

D. Safety hazards may be reported directly to the supervisor, manager, or to the City Human Resources Department. Safety and health complaints may be anonymous by calling the Human Resources Department at **(760) 391-4016**. Employees may also report a safety hazard by completing **"Hazard Report"** Form (**Attachment A**). The Human Resources Department will investigate the complaint received recommend corrective action, if necessary, to the Department.

E. Employees are encouraged to quickly and effectively inform their Department, either orally or in writing, of any hazards at the worksite. Upon notification, the supervisor is responsible for investigating the complaint and taking appropriate action such as placing a work request to resolve the problem, training employees, etc.

F. Employees are expected to learn and observe safety and health rules, procedures, and policies. They are also expected to use all required personal protective equipment and not remove safety guards from any equipment.

G. There shall be no reprisal against any employee who reports a safety hazard to Cal/OSHA, or anyone in his or her chain of command by any method listed above.

VII. PROCEDURES FOR REPORTING/PROCESSING WORKERS' COMPENSATION CLAIMS

Supervisors shall:

A. Call emergency medical services (911) for critical injuries or illnesses.

B. Call the Human Resources Department immediately if there is an employee death or serious injury/illness requiring hospitalization.

C. Complete the "**Authorization for Treatment**" (**Attachment B**). If the employee does not wish to go to the medical clinic at this time, complete the **"Supervisor's Incident/Accident Investigation Report"** and indicate that employee declined medical treatment.

D. The employee completes the top half of the **Employee's Claim Form for Worker's Compensation Benefits (Form DWC-1)**, *within 24 hours* of the event (**Attachment C**). The supervisor will complete the bottom section and ensure that the employee receives the copy marked "Employee Copy", then make the appropriate distribution of the remaining copies.

E. If needed, contact and provide Human Resources **(760) 391-4066** with any information about the event to assist in an expeditious and accurate assessment.

F. Route a copy of any medical reports provided by the injured employee to Human Resources, such as doctor's notes or status reports.

G. Accurately complete all sections of **"Supervisor's Incident/Accident Investigation Report"** (**Attachment D**) when conducting an accident investigation. Attach additional pages if needed.

VIII. PROCEDURES FOR ACCIDENT INVESTIGATION

A. The employee's supervisor must complete the **"Supervisor's Incident/Accident Investigation Report"** and investigate the reported injury or illness (**Attachment D**). This investigation shall include what occurred, what corrective action was/will be taken to prevent similar occurrences.

B. A fatal or serious injury or serious occupational illness exposure incident must be reported immediately by phone to the Human Resources Department at **(760) 391-4016**.

Cal/OSHA defines a Serious Injury or Illness as:

- An employee who is hospitalized for a period in excess of twenty-four hours, other than for medical observation or
- An employee who suffers any serious degree of permanent disfigurement or amputation of any part of his/her body or
- An employee who is killed while in the performance of his/her duties.

IX. RECORD KEEPING

Human Resources Department shall be responsible for maintaining the following records:

A. Copies of safety and health inspections, which will include the unsafe and unhealthy conditions and work practices found and records pertaining to the corrective action that was taken. These records shall be maintained for a period of three years.

B. Training records for each employee, to include employee's name or other identifier, training dates, types of training, training providers, and a description of the training program. These records must be maintained for three years.

C. Work injury/illness records to include the Supervisor's Incident/Accident Investigation Report. These records must be maintained for three years.

D. Cal/OSHA 300 Log of Occupational Injury and Illness. This log records all of the work related injuries and illnesses that result in time lost from work, medical treatment other than first aid, and limited duty time. This log shall be kept on the current calendar year and retained for five years.

E. Copies of Employee Hazard Report Forms that have been submitted by employees. These forms shall be maintained for three years.

4 Attachments:

A. Hazard Report / Supervisor's Response
B. Authorization for Treatment
C. Worker's Compensation Claim Form (DWC-1)
D. Supervisor's Incident/Accident Investigation Report

CITY OF INDIO
Human Resources Department
100 Civic Center Drive
Indio, CA 92201
(760) 391-4022

Hazard or Safety Report

		Complaint Number	
Location of Hazard			
Supervisor of Location			
City Department			

HAZARD DESCRIPTION/LOCATION. Describe briefly the hazard(s) which you believe exist. Include the approximate number of employees exposed to or threatened by each hazard. Specify the particular building or worksite where the alleged violation exists.

Has this condition been brought to attention of:	☐ Employer ☐ Other Government Agency (specify):
Please Indicate Your Desire:	☐ Do **NOT** reveal my name to my Employer ☐ My name may be revealed to the Employer
The Undersigned believes that a violation of an Occupational Safety or Health standard exists which is a job safety or health hazard at the establishment named on this form.	(Reporting Person, check ONE box) ☐ Employee ☐ Public Member ☐ Representative of Employees ☐ Other (specify):_____

Reporting Person		Telephone	
Address (Street, City State, ZIP)			
Signature		Date	

If you are an authorized representative of employees affected by this complaint, please state the name of the organization that you represent and your title.

Organization Name:	Your title:

Please submit reports to humanresources@indio.org or mail to:

Human Resources Department
100 Civic Center Drive
Indio, CA 92201

CITY OF INDIO
Human Resources Department
100 Civic Center Drive
Indio, CA 92201
(760) 391-4022

City of Indio Health & Safety
Supervisor Only

SUPERVISOR'S RESPONSE – WITHIN FIVE WORKING DAYS

☐ **I agree this is a hazard**

Date Corrected: _____

Estimated Date of Correction: _____

Action Taken: _____

_____

_____

☐ **Work Order Submitted (attach a copy)**

☐ **Training to be provided by date:** _____

☐ **Develop New or Modify Existing Policy/Procedure**

☐ **Provide Personal Protective Equipment**

☐ **Equipment Placed Out of Service**

☐ **I do not agree this is a hazard**

Reason: _____

_____

_____

_____
Supervisor's Signature

_____
Date

5-Hole 1/4 1 3/8 c-to-c

EISENHOWER OCCUPATIONAL HEALTH SERVICES

AUTHORIZATION FOR TREATMENT

Print Form

☒ 78-822 Hwy 111
La Quinta, CA 92253
760 777-7701

☐ 67-780 E. Palm Canyon Dr.
Cathedral City, CA 92234
760 328-5679

THIS MUST ACCOMPANY EMPLOYEE AT INITIAL VISIT

Employee Name _____ Date _____

Company Name City of Indio Phone 760-391-4016

Treatment Authorized By Ruby Ramirez Title _____

Modified Work Available? ☑ Yes ☐ No

AUTHORIZATION FOR *(please check all services that apply)*

☑ Work Injury Date of Injury _____ Time of Injury

*Blood and body fluid exposure: Proceed immediately to Eisenhower Medical Center, Emergency Department.

☐ Post Accident Urine Drug Screen ☐ D.O.T. (Dept. of Transportation) ☐ Non - D.O.T.

☐ Physical
- ☐ Basic ☐ Comprehensive
- ☐ Fit-For-Duty ☐ DMV/D.O.T.
- ☐ Respirator

APPOINTMENT DATE / TIME

_____

Bring Picture I.D.

☐ TB Screening ____ PPD ____ Chest Xray

☐ Hepatitis B ____ Vaccine ____ Titre

☐ Urine Drug Screen ☐ D.O.T. (Dept. of Transportation) ☐ Non - D.O.T.

Reason: ☐ Pre-placement ☐ Random ☐ Post Accident ☐ Reasonable Suspicion/Cause ☐ Other _____

☐ Breath Alcohol Screen

Reason: _____

☐ Other (specify): _____

CURRENT WORKER COMPENSATION CARRIER

Name of Insurance Company York

Address P.O. Box 619079 Roseville, CA 95661

Policy # _____ Adjuster Bill Larkin Phone (866) 221-2402

SPECIAL INSTRUCTIONS / COMMENTS:

If you would like to make changes in the services we currently are providing your company, please phone the Client Services Department at 760-770-1276

For Eisenhower Occupational Health Services locations, see maps on back.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
   _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    York Risk Services Group, Inc. P.O. Box 619079, Roseville, CA 95661
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* **866-221-2402**

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

York Risk Services Group, Inc.

P.O. Box 619079, Roseville, CA 95661

Phone: (866) 221-2402 Fax: (866) 548-2637

OSHA Case No.

Fatality ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME

1A. POLICY NUMBER

2. MAILING ADDRESS (Number, Street, City, Zip)

2A. PHONE NUMBER

3. LOCATION if different from Mailing Address (Number, Street, City and Zip)

3A. LOCATION CODE

4. NATURE OF BUSINESS, e.g. Painting contractor, wholesale grocer, sawmill, hotel, etc.

5. STATE UNEMPLOYMENT INSURANCE ACCT. NO

6. TYPE OF EMPLOYER
☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ OTHER GOVERNMENT - SPECIFY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm / dd / yy)

8. TIME INJURY/ILLNESS OCCURRED
_____ AM _____ PM

9. TIME EMPLOYEE BEGAN WORK
_____ AM _____ PM

10. IF EMPLOYEE DIED, DATE OF DEATH (mm / dd/ yy)

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY ☐ YES ☐ NO

12. DATE LAST WORKED (mm / dd / yy)

13. DATE RETURNED TO WORK (mm / dd / yy)

14. IF STILL OFF WORK, CHECK THIS BOX ☐

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO

16. SALARY BEING CONTINUED?
☐ YES ☐ NO

17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm / dd / yy)

18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm / dd / yy)

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip

20a. COUNTY

21. ON EMPLOYER'S PREMISES?
☐ YES ☐ NO

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop

23. Other Workers Injured/Ill in this event?
☐ YES ☐ NO

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)

27a. Phone Number

28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ NO ☐ YES If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)

28a. Phone Number

29. Employee treated in Emergency Room? ☐ ☐

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*

EMPLOYEE

30. EMPLOYEE NAME

31. SOCIAL SECURITY NUMBER

32. DATE OF BIRTH (mm / dd / yy)

33. HOME ADDRESS (Number, Street, City, Zip)

33a. PHONE NUMBER

34. SEX
☐ MALE ☐ FEMALE

35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)

36. DATE OF HIRE (mm / dd / yy)

37. EMPLOYEE USUALLY WORKS
_____ hours per day. _____ days per week. _____ total weekly hours

37a. EMPLOYMENT STATUS
☐ regular, full-time ☐ part-time
☐ temporary ☐ seasonal

37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?

38. GROSS WAGES/SALARY
$ _____ per _____

39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY
☐ YES ☐ NO (e.g., tips, meals, overtime, bonuses, etc.)?

Completed By (type or print)

Signature & Title

Date (mm / dd / yy)

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCT Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) JUNE 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

CITY OF INDIO

Human Resources Department
100 Civic Center Drive
Indio, CA 92201
(760) 391-4022

SUPERVISOR'S INCIDENT / ACCIDENT INVESTIGATION REPORT

DEPARTMENT OR DIVISION		NAME OF IMMEDIATE SUPERVISOR MAKING REPORT (PRINT)	PHONE NO.
LOCATION OF INCIDENT		DATE OF OCCURENCE	TIME ☐ AM ☐ PM / DATE REPORTED
PERSONAL INJURY		**PROPERTY DAMAGE**	
INJURED'S NAME		PROPERTY DAMAGED	
OCCUPATION	INJURED PART OF BODY	ESTIMATED COSTS	ACTUAL COSTS (LEAVE BLANK)
NATURE OF INJURY		NATURE OF DAMAGE (IF NONE, PLEASE STATE)	

DESCRIPTION

DESCRIBE IN DETAIL HOW THE INCIDENT OCCURED: (Attach seperate pages if necessary)

ANALYSIS

WHAT ACTS AND/OR CONDITIONS CONTRIBUTED MOST DIRECTLY TO THIS INCIDENT?

01 Inadequate training
02 Inadequate equipment/tools
03 Inadequate protective gear
04 Poor housecleaning
05 Inadequate facility maintenance
06 Inadequate equipment maintenance
07 Employee physical limitations
08 Poor planning, layout, design
09 Inadequate procedure
10 Failure to follow procedures
11 Emergency / haste
12 Hazard exposure / haste
13 Environmental factors
14 Act of another
15 Vandalism
16 Horseplay
17 Inattention
18 Insufficient information
19 Unknown cause
20 Assault
21 Vegetation (poison oak/ivy)

PRIMARY CAUSE CODE _____
SECONDARY CAUSE CODE _____
Miscellaneous _____
(Explain)

PREVENTION

IN DETAIL WHAT ACTION HAS OR WILL BE TAKEN TO PREVENT RECURRENCE? PLACE AN X BY ITEMS COMPLETED

HAS EMPLOYEE RETURNED TO WORK? ☐ Yes, Date returned _____ ☐ No	I HAVE THOROUGHLY INVESTIGATYED THE ABOVE INCIDENT, ☐ Yes ☐ No	THE INFORMATION AS GIVEN IS COMPLETE AND CORRECT ☐ Yes ☐ No
SIGNATURE OF IMMEDIATE SUPERVISOR / DATE		SIGNATURE OF DEPARTMENT DIRECTOR / DATE

White-Safety Committee • Canary-Human Resources • Pink-Department • Goldenrod-Workers Comp. Carrier (for injuries)

REVISE 3/09

FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY