COMPASS
CONSTRUCTION

SUBCONTRACTOR

Injured Worker Packet

1. **Attend to injured worker, safe off and secure the scene**

2. **Call the Safety Director**

Incident Date: _____

Project Name: _____

Subcontractor:_____

Injured Worker Name:_____

Subcontractor Supervisor:_____

Compass Superintendent: _____

Once the packet is complete, please scan and send to the Safety Director and HR.
Place a copy in the Project Safety Folder.

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Subcontractor Employee

Injured Worker Checklist

**It is the responsibility of the Project Superintendent to ensure this checklist and packet are complete and all documentation is filled out to the best of his/her ability.*

- ☐ **Fill out the front cover page**
- ☐ **Superintendent has reviewed the Accident and Injury Investigation outline WAC- 296-800-320**
- ☐ **Superintendent and Subcontractor Supervisor has reviewed and filled out the Accident/Injury Report with the injured employee**
- ☐ **Injured Worker Statement has been filled out and signed by both injured worker and their Supervisor**
- ☐ **Witness forms have been filled out and signed**
- ☐ **Third Party form has been filled out and signed (if applicable)**
- ☐ **Injured employee has been given the Accident and Injury Investigation Packet to review and complete applicable forms**
- ☐ **All completed forms scanned and sent to the Safety Director and HR Place a copy in the Project Safety Folder**

ACCIDENT AND INJURY INVESTIGATION

WAC 296-800-320

All accidents and injuries, no matter how minor, are to be reported promptly to the immediate supervisor for evaluation and if necessary, investigation. Since every accident includes a sequence of contributing causes, it is possible to avoid a repeat performance of the first event by recognizing and eliminating these causes. The removal of just a single cause can prevent a recurrence. Through a comprehensive accident and injury investigation future incidents will be prevented from happening.

Contents

Determining Incident Occurrence

Determine if an accident occurred

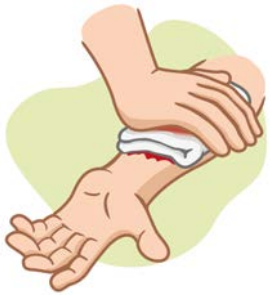
The first step in accident and injury investigation is determining whether an injury or illness has occurred. Usually this is a simple process, but some cases are difficult to determine. A couple of scenarios that often pose problems are:

- ❑ Getting the injured to the hospital for observation.
- ❑ If no medical treatment is given and no illness was discovered, hospitalization for observation is not recordable.
- ❑ Differentiating a new case from the recurrence of a previous injury or illness.
- ❑ Establish that the incident was work-related.

Employers only have to record and be concerned about (for worker compensation purposes) injuries or illnesses that occur in “course of employment” of their workforce. Each employee will be thoroughly questioned about the nature and causation of the act(s) that resulted in their injury.

ACCIDENT AND INJURY INVESTIGATION

WAC 296-800-320



Determine whether the incident is an injury or an illness

The distinction between injuries and illnesses is important for recordkeeping. For OSHA recordkeeping purposes, a case is defined as an injury or illness by the nature of the event or exposure, which caused the case, not by the resulting condition.
(See the OSHA Recordkeeping section in the manual).

NOTE: Injuries are caused by an instantaneous event. Cases resulting from anything other than an instantaneous event is considered an illness. Some conditions can be classified as both injuries and illnesses depending on the cause. For example, a loss of hearing from an explosion is an injury; while a loss of hearing from exposure to noise over a period of time is an illness.

Basic Accident Investigation

All accidents, fatalities, major injuries, minor injuries or a close-call, require investigation. There are no exceptions. The investigation will be carried out by the safety committee and discussed at the next safety meeting.

- The purpose of an investigation is to find the cause of an accident and prevent any recurrences, not to fix blame. An unbiased approach is necessary to obtain objective findings.
- Visit the accident scene as soon as possible - while facts are fresh and before witnesses forget important details.
- If possible, interview the injured worker at the scene of the accident and ‘'walk” through a “re-enactment”. Be careful not to actually repeat the act that caused the injury.
- All interviews should be conducted as privately as possible. Interview witnesses one at a time. Talk with anyone who has knowledge of the accident, even if they did not actually witness the mishap.
- Consider taking signed statements in cases where facts are unclear or there is an element of controversy.
- Graphically document details of the accident; area, tools and equipment. Use sketches, diagrams and photos as needed, and take measurements when appropriate.
- Focus on causes and hazards. Develop an analysis of what happened, how it happened, and how it could have been prevented. Determine what caused the accident itself, not just the injury.
- How will you prevent such accidents in the future? Every investigation should include an action plan.
- If a third party or defective product contributed to the accident, save any evidence. It could be critical to the recovery of the claim costs.

ACCIDENT AND INJURY INVESTIGATION

WAC 296-800-320

Handling Major Injuries and Illnesses

(Fatality or multiple hospitalization)

In the case of a fatality hospitalization of 1 or more employees from the same incident, the supervisor must report the accident to the nearest DOSH Office within 8 hours. After hours, call 800-321-6742. Any equipment involved in an accident resulting in an immediate fatality is not to be moved until a representative of DOSH investigates the accident and authorizes removal. If it is necessary to move the equipment to prevent further accidents or to remove the victim, the equipment may be moved as required.

Information that must be recorded at the site of the accident:

- ❑ Time and date of accident event
- ❑ Employer's name, address and phone
- ❑ Name and job title of person reporting accident
- ❑ Address of accident event site
- ❑ Name of contact at accident event site
- ❑ Name and address of injured employee
- ❑ Nature of injuries
- ❑ Location where injured employee(s) were taken for treatment
- ❑ List of other law enforcement agencies at the accident event site
- ❑ Description of accident event and whether the accident scene has been altered

Near-Miss Incidents

(Likelihood of personal injury or property damage)

To the greatest extent possible, all "near-miss" accidents shall be investigated and documented by a supervisor and a member of the safety committee.

Documentation and Recordkeeping Procedures

After the emergency actions following an accident or injury, an investigation of the accident will be conducted by the immediate supervisor in conjunction with any witnesses to the accident to determine the causes. The findings of the investigation shall be documented on:

- ❑ Report of Accident and Injury Form

  Purpose: Serves as record for injuries

  Utilization: The supervisor fills this form out every time an injury occurs regardless if the employee sought medical attention

  Routing Copies To: a) Employees Medical File
  b) Company's Accident and Injury File
  c) Claims Management Service

- ❑ Accident Witness Statement Form

  Purpose: Enables supervisors to collect additional information for accident causation analysis and potential litigation

  Utilization: The supervisor fills this form out during their investigation of an accident or injury

ACCIDENT AND INJURY INVESTIGATION

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Routing Copies To:

a) Insurance Carrier and/or Claims Management Service
b) Accident File

- Third Party Involvement Form:

  Purpose — Enables management to record data regarding a third party who may be at fault for losses

  Utilization — The supervisor fills this form out during their investigation of an accident or injury

  Routing Copies To:

  a) Insurance Carrier and/or claims management service.
  b) Accident File

Distribution of the completed form(s) will be as follows:

A Copy of the Report of Accident and Injury is:

- Placed in employee's injury or claim file.
- Placed in supervisor's accident occurrence file.
- Given to Safety Committee Chairperson.

A Copy of the Accident Witness Statement Form is:

- Placed in a separate file that is created specifically for a particular accident or injury.
- Forwarded to insurance carrier or claims management service.

A Copy of the Accident Causation Form is:

- Placed in the supervisor's accident occurrence file.
- Given to the Safety Committee Chairperson.
- Given to Senior Management if it is merited.

A Copy of the Third Party Involvement Form is:

- Placed in a separate file that is created specifically for a particular accident or injury.

All medical records must be filed separately from all other personnel records.

ACCIDENT INVESTIGATION

- Gather information and establish facts
- Isolate essential contributory factors
- Determine Corrective Actions
- Implement Corrective Actions

ACCIDENT AND INJURY INVESTIGATION

WAC 296-800-320

GATHER INFORMATION AND ESTABLISH FACTS

FACT GATHERING

- Be impartial and objective
- Compile procedures and rules for the area
- Gather maintenance records on equipment involved
- Isolate accident scene
- Photos and diagrams
- Do not discard or destroy anything
- Time is of the essence
- Obtain Information
- Injured worker(s) witnesses
- Supervisor names
- Other Personnel Names

ISOLATE ESSENTIAL CONTRIBUTORY FACTORS

- Interviews (Completed separately)
  - What were you doing?
  - How do you think the accident occurred?
  - How were you trained for the job??
  - What is the safety procedure for this job?

- Obtain facts not opinions
  - Make it clear the object of the investigation is to avoid recurrence, not to apportion blame
- Do not assume anything!

DETERMINE CORRECTIVE ACTIONS

SAFETY COMMITTEE OR INVESTIGATION TEAM:

- Interprets and draws conclusion
- Distinction between intermediate and underlying causes
- Recommendations based on key Contributory factors and underlying causes

IMPLEMENT CORRECTIVE ACTIONS

- Recommendations(s) must be communicated clearly
- Strict time table established
- Follow up conducted

ACCIDENT AND INJURY INVESTIGATION

WAC 296-800-320

BENEFITS OF ACCIDENT INVESTIGATION

- Preventing recurrence
- Identifying out-mode procedures
- Improvements to work environment
- Increased productivity
- Improvement of operational and safety procedures
- Raises safety awareness level
- When an organization reacts swiftly and positively to accidents and injuries, its actions reaffirm its commitment to the safety and well-being of its employees

COMPASS
CONSTRUCTION

Subcontractor - Injured Worker

Steps to Handling and Reporting an Injury / Illness

An Accident is any unplanned event – which means an accident does not have to be a personal injury.

1. **Administer First Aid** or call relevant emergency services, i.e., Police, Fire, Ambulance, etc. Do not attempt to move the injured worker if injury is severe. Do not let the injured worker drive themselves to the medical facility. Provide other means for transportation.

2. **Call the Jobsite Superintendent** (if applicable)

3. **Immediate Hazard**
   a. Safe off any hazards that are an immediate danger to life
   b. Isolate/protect the accident scene
   c. Protect any key evidence (identify and secure)

4. **Call Safety Director**

5. **Prepare Documentation**
   a. Obtain witness statements
   b. Obtain photos of accident scene
   c. Investigate cause
   d. Compass supervisor to complete an Injured Worker Packet for all accidents/injuries
   e. If the injured worker is taken to a medical facility, make sure to get an **Activity Prescription Form** from the treating physician.
   f. The injured worker may not return to work without an **Activity Prescription Form** from the physician.
   g. **Scan and/or e-mail all documents (reports, photos, and witness statements)** to the Safety Director and HR Department.
   h. K**eep copies** for project files.

6. **For Workers Comp, General Liability, or Auto, the Main Office will handle from this point forward.**
   a. HR will forward reports to: Aspire Consulting

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ACCIDENT / INJURY / ILLNESS REPORT

To be completed by Superintendent

☐ INJURY ☐ ILLNESS

Job Name		Job #		Date	
Address		City		State	

Time of Accident		AM / PM	Weather / Temp	

Injured Persons Name		Reported By	
Employer		Date Reported	

Description: (Describe sequence of events, what was the employee doing. What equipment / materials were being used?)

Photos taken:	☐ Yes	☐ No	Include Photos with Report

Did equipment malfunction?	☐ Yes	☐ No	If Yes, please describe equipment and malfunction:

Did injured worker go to the doctor/hospital?	☐ Yes	☐ No	If so where?	
Did injured worker return to work?	☐ Yes	☐ No	If so when?	

Note: Send the Activity Prescription Form to Subcontractor's Supervisor. Employee cannot return to work until approval from the physician, their supervisor and Compass Safety Director.

Immediate corrective actions that have or are being taken.	

Please list and attach statements from each key witness:

Name(s):	Employer(s):

Sub Supervisor:			
Superintendent:		Date:	
Safety Director:		Date:	

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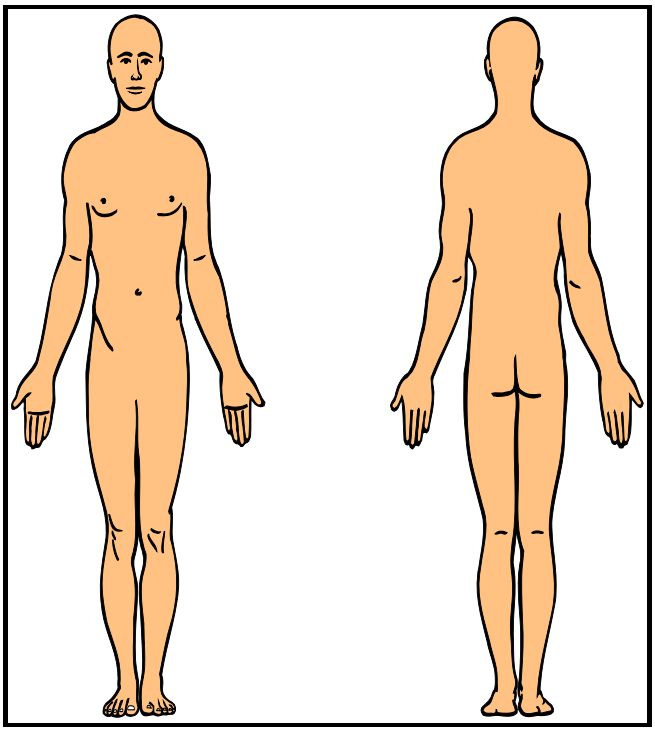
Description of injury/illness, part of body effected. Be as descriptive as possible. (including equipment, material or chemicals being used).

Indicate Part of Body Injured (Circle)



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WITNESS STATEMENT

Check One:		ACCIDENT		INCIDENT		INJURY		ILLNESS
Full Name:								
Witness Email:								
Your Address:								
Company Name:					Job Title:			
Phone Number:					Cell:			
Date of Incident:					Time of Incident:	AM		PM

1. What were you doing at the time of the event?

2. Describe in detail what happened? Include all details.

3. So you have any additional thoughts and/or comments?

This statement completed by:

Print Name: _____

Signature: _____ **Date:** _____

Superintendent Signature: _____ **Date:** _____

Interpreted By: _____ **Date:** _____

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Draw any diagrams that you feel would help substantiate what you witnessed.

Additional comments:

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CONSTRUCTION

WITNESS STATEMENT

Check One:		ACCIDENT		INCIDENT		INJURY		ILLNESS
Full Name:								
Witness Email:								
Your Address:								
Company Name:					Job Title:			
Phone Number:					Cell:			
Date of Incident:					Time of Incident:	AM		PM

1. What were you doing at the time of the event?

2. Describe in detail what happened? Include all details.

3. So you have any additional thoughts and/or comments?

This statement completed by:

Print Name: _____

Signature: _____ **Date:** _____

Superintendent Signature: _____ **Date:** _____

Interpreted By: _____ **Date:** _____

COMPASS
CONSTRUCTION

Draw any diagrams that you feel would help substantiate what you witnessed.

Additional comments:

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CONSTRUCTION

WITNESS STATEMENT

Check One:		ACCIDENT		INCIDENT		INJURY		ILLNESS
Full Name:								
Witness Email:								
Your Address:								
Company Name:					Job Title:			
Phone Number:					Cell:			
Date of Incident:					Time of Incident:	AM		PM

1. What were you doing at the time of the event?

2. Describe in detail what happened? Include all details.

3. So you have any additional thoughts and/or comments?

This statement completed by:

Print Name: _____

Signature: _____ **Date:** _____

Superintendent Signature: _____ **Date:** _____

Interpreted By: _____ **Date:** _____

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CONSTRUCTION

Draw any diagrams that you feel would help substantiate what you witnessed.

Additional comments:

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THIRD PARTY INVOLVEMENT

Subcontractor / General Public

Date:_____

Name of injured worker: _____ Title:_____

Company Name:_____

***IF ADDITIONAL WORKERS ARE INJURED PLEASE ATTACH THEIR INFORMATION TO THIS SHEET**

Date of accident or injury:_____Time of accident or injury:_____

Name of Company and/or individual responsible for the accident:

_____

Company address:_____

Insurance Carrier of Third Party:_____

Policy Number:_____ Phone Number:_____

Building, equipment, machinery or vehicle description involved in the accident:
(List make, model, year and license plate numbers)

_____

_____

_____

The address of where the accident took place and the location description:

_____

_____

_____

_____

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1. How could the accident have been prevented?

Explain: _____

_____

_____

2. Was there a disciplinary action documented? ☐ Yes ☐ No

Explain: _____

_____

3. Was corrective action taken? ☐ Yes ☐ No

_____

_____

(Each witness will need to provide a separate statement)

LIST OF WITNESSES

NAME: _____

STREET ADDRESS: _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER: _____

NAME: _____

STREET ADDRESS: _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER: _____

NAME: _____

STREET ADDRESS: _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER: _____

WAS A POLICE REPORT FILED? ☐ Yes ☐ No

Jurisdiction of police _____ **Police report ref. #** _____

Supervisor signature: _____ **Date:** _____

COMPASS
CONSTRUCTION

SUBCONTRACTOR - INJURED WORKER
STATEMENT

Check One:		ACCIDENT		INCIDENT		INJURY		ILLNESS
Full Name:								
Your Address:								
Company Name:					Job Title:			
Phone Number:					Cell:			
Date of Incident:					Time of Incident:	AM		PM

1. What were you doing at the time of the event?

2. Describe in detail what happened? Include all details.

3. So you have any additional thoughts and/or comments?

This statement completed by:

Print Name: _____

Signature: _____ **Date:** _____

Superintendent Signature: _____ **Date:** _____

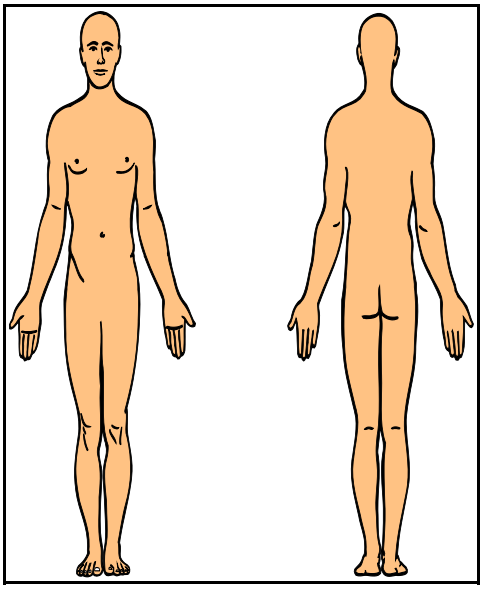
Interpreted By: _____ **Date:** _____

COMPASS
CONSTRUCTION

Draw any diagrams that you feel would help substantiate what happened.

Description of injury/illness, part of body effected. Be as descriptive as possible. (including equipment/material/chemical being used).

Indicate Part of Body Injured (Circle)



State Fund Claim:
Department of Labor and Industries PO
Box 44291 Olympia WA 98504-4291
Fax to claim file: 360-902-4567
Self-Insured Claims: Contact the Self Insured Employer (SIE)/Third Party Administrator (TPA)
For a list of SIE/TPAs, go to www.Lni.wa.gov/SelfInsured

Activity Prescription Form (APF)

Billing Code: 1073M (Guidance on back)

Reminder: Send chart notes and reports to L&I or SIE/TPA as required. Complete this form only when there are changes in medical status or capacities, or change in release for work status.

General info

Worker's Name:	Patient ID:	Visit Date:	Claim Number:
Healthcare Provider's Name (please print):		Date of Injury:	Diagnosis:

Required: Work status

☐ Worker is **released** to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ____/____/____
(*If selected, skip to "Plans" section below)*

☐ Worker **may perform modified duty**, if available, from (date):
_____/_____/_____ to* _____/_____/_____ (*estimated date)
☐ If released to modified duty, may work more than normal schedule

☐ Worker **may work limited hours**: _____ hours/day from (date):
_____/_____/_____ to* _____/_____/_____ (*estimated date)

☐ Worker **is working** modified duty or limited hours

☐ Worker **not released to any work** from (date): ____/____/____ **to*** __/____/____
(*estimated date)

☐ **Poor prognosis for return to work** at the job of injury at any date

Required: Measurable Objective Finding(s)
(e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)

Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?
☐ **1-10 days** ☐ **11-20 days** ☐ **21-30 days** ☐ **30+ days** ☐ **permanent**
Capacities apply all day, every day of the week, at home as well as at work.

Worker can: (Related to work injury) A blank space = Not restricted	**Never**	**Seldom** 1-10% 0-1 hour	**Occasional** 11-33% 1-3 hours	**Frequent** 34-66% 3-6 hours	**Constant** 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach **L**eft, **R**ight, **B**oth					
Work above shoulders **L, R, B**					
Keyboard **L, R, B**					
Wrist (flexion/extension) **L, R, B**					
Grasp (forceful) **L, R, B**					
Fine manipulation **L, R, B**					
Operate foot controls **L, R, B**					
Vibratory tasks; high impact **L, R, B**					
Vibratory tasks; low impact **L, R, B**					

Lifting / Pushing	**Never**	**Seldom**	**Occas.**	**Frequent**	**Constant**
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift **L, R, B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Carry **L, R, B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Push / Pull **L, R, B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐Yes ☐No
Modified duty available? ☐Yes ☐No
Date of contact: _____/_____/_____
Name of contact: _____
Notes:

Note to Claim Manager:

☐ May need assistance returning to work
New diagnosis:_____
Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

Required: Plans

Worker progress: ☐ As expected / better than expected
☐ Slower than expected (*address in chart notes*)

Current rehab: ☐ PT ☐ OT ☐ Home exercise
☐ Other (e.g., Activity Coaching) _____

Surgery: ☐ Not Indicated ☐Possible
☐ Planned Date: ____/____/____
☐ Completed Date: ____/____/____

☐ Next scheduled visit in: ___days ___weeks or Date: ___/___/___
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐Yes ☐No ☐Possibly
If you are qualified, please rate impairment for your patient
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to: _____
☐ Consultation needed with: _____
☐ Study pending: _____

Reg: Sign

☐ Copy of APF given to worker ☐ Discussed three key messages on back of form with patient

Signature: _____ _____/_____/_____ ( ) _____-_____
☐ Doctor ☐ ARNP ☐ PA-C Date Phone

RESET

Index: **APF**

Discuss your patient's role in their recovery
Research has shown that returning to activity (including lighter work) speeds recovery and reduces the risk of becoming disabled from most work-injuries. In addition to providing good clinical care, it is important to set expectations for a good recovery and assure patients understand the importance of doing their part. Take just a couple minutes during an initial office visit to explain the following (check each one as you complete it):

Key Messages

1. **"You must help in your own recovery…"**
   - Only you can ensure your own successful recovery.
   - It's your job (and my expectation) that you follow activity recommendations (both at home and at work).
2. **"Activity helps recovery…"**
   - Bodies heal best with activity that you can safely do, and need to do, to recover.
   - Incrementally increase the activity you do a little bit, each day.
   - Some discomfort is normal when returning to activities after an injury. This is not harmful, and is different from pain that indicates a setback.
3. **"Early and safe return to work makes sense…"**
   - Return to work is one of the goals of treatment.
   - The longer you are off work, the harder it is to get back to your original job and wages.
   - Even a short time off work takes money out of your pocket because time loss payments do not pay your full wage.

To be paid for this form, providers must:

1. Submit this form:
   - With reports of accident when there are work related physical restrictions, or
   - When documenting a change in your patient's medical status or capacities.
2. Complete all relevant sections of the form.
3. Send chart notes and reports as required.

Important notes

- A provider may submit up to 6 APFs per worker within the first 60 days of the initial visit date and then up to 4 times per 60 days thereafter.
- Use this form to communicate expectations of the patient to be physically active during recovery, work status, activity restrictions, and treatment plans.
- This form will also certify time-loss compensation, if appropriate.
- Occupational and physical therapists, office staff, and others will not be paid for working on this form.

To learn how to complete this form, go to www.Lni.wa.gov/activityRX.

About impairment ratings

We encourage you, the qualified attending health-care provider, to rate your patient's permanent impairment. If this claim is ready to close, please examine the worker and send a rating report.

Qualified attending health-care providers include doctors currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and chiropractors who are department-approved examiners.

Thank you for treating this injured worker.