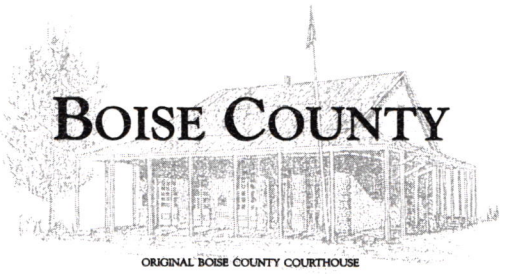
Rescinded by 2004-03 1-6-04

ORIGINAL

BOISE COUNTY



ORIGINAL BOISE COUNTY COURTHOUSE

RESOLUTION #2003-13

A RESOLUTION ADOPTING BOISE COUNTY SAFETY AND LOSS PREVENTION POLICY STATEMENT AND ACCIDENT REPORTING POLICY MAKING THE SAME A PART OF THE COUNTY'S PERSONNEL POLICY ADOPTED BY RESOLUTION #2003-01, AND PROVIDING AN EFFECTIVE DATE

WHEREAS, Boise County is committed to providing the safest and healthiest possible working conditions for all its employees with the goal of decreasing the number of safety and health related accidents, injuries, property damage, and losses throughout the County, and;

WHEREAS, to assist in this goal, the County is adopting a Management Safety Policy and making the same a part of the Boise County Personnel Policy, and;

WHEREAS, Boise County maintains that the best source of protection for the health and safety of the work force is the individual employee. Therefore, it is the responsibility of all employees to strictly follow all safety and health policies and procedures.

NOW, THEREFORE, BE IT RESOLVED that the following Management Safety Policy be and the same is hereby adopted by the Boise County Board of Commissioners and made a part of the Boise County Personnel Policy Manual effective August 25, 2003, to wit:

The safety and health of the employees of Boise County is of primary importance. The county policy is to provide safe and healthy working conditions and operating practices that will ensure a safe work environment for employees.

Boise County is committed to establish and maintain communication with all employment levels to keep employees aware of the safety and health factors of their jobs.

Boise County is committed to making reduction, control, and elimination of risks a top priority in all plans and budgets.

Boise County has established and will maintain an accident and injury reporting system and a record keeping system.

All levels of management have a primary responsibility for the safety of all employees to preclude accidents. The employee, in turn, is expected to adhere to the regulations and policy outlined by Boise County.

These responsibilities can be met only by working continuously to promote safe work practices among all employees and to maintain property and equipment in a safe operating condition. By working together, we can maintain a safe working environment for all employees.

Phone (208) 392-6636
FAX (208) 392-4473

P.O. Box B.C.
Idaho City, Idaho 83631

FURTHER BE IT RESOLVED, that the following Accident and Injury Reporting Policy be set and adopted by the Boise County Board of Commissioners:

Accident and Injury Reporting Policy

A. Non-Vehicular Accidents

Any employee involved in a non-vehicular accident that occurs in conjunction with County business must report the accident on the "Worker's Compensation Report of Injury or Illness Form" provided by the State Insurance Fund. The report must be submitted to the Elected Official or Department Supervisor as soon as possible after the accident for his/her review and signature acknowledging awareness of the incident. The Elected Official or Department Supervisor shall immediately fill out the "Supervisor's Accident Investigation and Report Form" and forward the original reports to the County Risk Manager. A copy of both forms will remain with the employee's supervisor for future reference.

B. Vehicular Accidents

Any employee involved in a vehicle accident while on official County Business, either in a County or a private-owned vehicle, must report the accident on the County's "Property/Liability Notice of Incident" form. The incident form will be submitted to the Elected Official or Department Supervisor as soon as possible after the accident for his/her review and signature acknowledging awareness of the incident. The Elected Official or Department Supervisor will immediately forward the original incident form to the County Risk Manager for appropriate claim processing with the County's insurance carrier. A copy of incident form will remain with the employee's supervisor for future reference.

1. Exception: Reportable vehicular accidents involving County law enforcement vehicles will be investigated by the Idaho State Police or another appropriate outside agency. The investigating agency's original report will be attached to the "Property/Liability Notice of Incident" form and will be forwarded to the Risk Manager for claim processing with the County's insurance carrier. A copy of both forms will remain with the employee's supervisor for future reference.

FURTHER BE IT RESOLVED, that the following Record Keeping System be set and adopted by the Boise County Board of Commissioners:

Record Keeping System:
It is the responsibility of the Risk Manager to maintain all original documents of the Accident and Injury Reporting process on file in the Clerk's office. It is the responsibility of each Elected Official and/or Department Head to maintain copies of all reports submitted to the Risk Manager for future reference.

APPROVED and ADOPTED by the Boise County Board of Commissioners in open session on this 25th day of August 2003, with an immediate effective date.

BOARD OF BOISE COUNTY COMMISSIONERS

Absent
Roger B. Jackson, Chairman of the Board

Fred H. Lawson, Commissioner

Dale Hanson, Commissioner

Attest:

Rora A. Canody, Clerk to the Board

WHITE — ORIGINAL
YELLOW — SUPERVISOR'S COPY

SUPERVISOR'S ACCIDENT REPORT

Employer _____ Organizational code _____

Name of employee _____

Address _____

Occupation _____ Location code _____

Location of accident _____

Date of accident _____ 19___ Time _____ AM PM

Date Supervisor notified _____ 19___ Time _____ AM PM

Was employee on duty at time of accident? _____

Did employee leave work? _____ Date _____ Time _____ AM PM

Did employee return to work? _____ Date _____ Time _____ AM PM

How did accident happen? (State specific job being done, machinery, tools or objects involved and factors contributing to the accident) _____

_____

_____

_____

_____

Names of witnesses _____

Nature of injury _____
(Cut, bruise, strain, etc.)

Part of body _____
(Right leg, left ankle, lower back, etc.)

Name and address of treating physician or hospital _____

_____

Was accident caused by noncompany person or faulty equipment? _____ If yes,

identify: _____

_____

Were mechanical guards or other safe guards provided? _____

Was employee using them? _____

What corrective action has been taken to prevent similar accidents? _____

_____

_____

_____

_____

Date _____ 19___ _____
Supervisor

Reviewed by: _____ _____
Position

State Insurance Fund
Boise, Idaho 83720

SIF 17-82 Rev. 8/84

NOTICE OF LOSS/ACCIDENT

TYPE OF LOSS - AUTO ☐ LIABILITY ☐ PROPERTY ☐

INSURED

	CLAIM NUMBER	
ZIP	PERSON TO CONTACT	PHONE

LOSS

DATE AND TIME AM PM	LOCATION

DESCRIPTION OF LOSS

MOTOR VEHICLE ACCIDENT

MEMBER VEHICLE: YEAR, MAKE, MODEL	LICENSE NUMBER	VIN (VEHICLE IDENTIFICATION NUMBER)
DRIVER'S NAME AND ADDRESS ZIP		DEPARTMENT
DRIVER'S LICENSE NUMBER	DRIVER'S AGE	RESIDENCE PHONE ( ) / BUSINESS PHONE ( )
DESCRIPTION OF DAMAGE	WHERE VEHICLE CAN BE SEEN	Unit Number

PROPERTY DAMAGE

DESCRIBE PROPERTY (IF AUTO: YEAR, MAKE, MODEL, PLATE NO.)		COMPANY OR AGENCY NAME AND POLICY
OWNERS NAME AND ADDRESS		RESIDENCE PHONE ( ) / BUSINESS PHONE ( )
DRIVER'S NAME AND ADDRESS (CHECK IF SAME AS OWNER) ☐		RESIDENCE PHONE ( ) / BUSINESS PHONE ( )
DESCRIBE DAMAGE	ESTIMATE AMOUNT $	WHERE PROPERTY CAN BE SEEN / FIRE, HAIL, ETC

INJURED

NAME AND ADDRESS	PHONE	PED	INS VEH	Other VEH	AGE	Hospital or Doctor	Describe Injury

WITNESSES OR PASSENGERS

NAME AND ADDRESS	PHONE	INS VEH	Other VEH	OTHER (SPECIFY)

POLICE

POLICE INVESTIGATE? YES ☐ NO ☐	POLICE AGENCY	CHARGES?	INVESTIGATING OFFICER	Report Number

LIABILITY

ALLEGED OFFENCE		OFFICIALS INVOLVED
CLAIMANT - NAME AND ADDRESS		RESIDENCE PHONE ( ) / BUSINESS PHONE ( )
REMARKS		
DATE	REPORTED BY / REPORTED TO	SIGNATURE

Workers Compensation - First Report of Injury or Illness

Every work injury that requires medical services other than first-aid treatment must be reported within **TEN** days after the employer has knowledge of the injury. **Filing this report is not an admission of liability.** This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made.

Employer

Employer's name

Address

City State ZIP

Employer's location address (if different)

Address

City State ZIP

Policy number Organization code

Employer status

☐ Sole Proprietor ☐ LLC ☐ Public

☐ Partnership ☐ Corporation ☐ Other

Is injured worker a Corporate Officer, Partner, LLC Member, or the Sole Proprietor? ☐ Yes ☐ No

If a Sole Proprietorship, is the injured worker a household member? ☐ Yes ☐ No

Employee

Employee's last name

Employee's first name M.I.

Address

City State ZIP

Phone # Social Security #

Date of birth Date Hired

Under what class code were wages reported? Injury date

Regular department

Marital status ☐ Single ☐ Widowed ☐ Other ☐ Married ☐ Separated

State where hired

Occupation

Employment status

Sex ☐ Female ☐ Male

Wages

Wage rate $ per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Other

Hours worked per week

# of days worked per week

Full pay for the day of injury? ☐ Yes ☐ No

Did salary continue? ☐ Yes ☐ No

If board, lodging, or other advantages furnished in addition to wages, give estimated value per week. $

If gratuities (tips, etc.) were received in the course of employment, give estimated value per week. $

Accident or Exposure

Place of accident or exposure (address) City/State

County Did injury/illness occur on the employer's premises ☐ Yes ☐ No

Time injury occurred ☐ AM ☐ PM Time employee began work ☐ AM ☐ PM

Date last worked Date employer notified Date disability began

Date returned to work If fatal, date of death Injury type (strain, cut, etc)

Part of body affected Body part injured before? ☐ Yes ☐ No

Injury reported to (name and phone #)

Equipment, materials or chemicals employee was using upon occurrence

How injury or illness occurred (Describe the sequence of events. Include objects or substances that directly caused the injury.)

Was accident caused by failure of a machine or product? ☐ Yes ☐ No

If accident was caused by any person or business other than the injured worker, co-worker or the employer, please identify

Was safety equipment provided? ☐ Yes ☐ No

Was it used? ☐ Yes ☐ No

Were other workers also injured? ☐ Yes ☐ No

List other workers' names

Medical

Physician or hospital (name and address)

☐ No medical treatment ☐ Minor by Employer

☐ Minor - clinic/hospital ☐ Emergency care

☐ Anticipated major med/lost time ☐ Hospitalized overnight

Did anyone witness the accident? ☐ Yes ☐ No If yes, provide name, phone #

Preparer's name and title

Preparer's Phone number Date Prepared

Employer should keep yellow copy of this form for their records.

Send original to: **State Insurance Fund, PO Box 83720, Boise ID 83720-0044.** Phone 1-800-334-2370 or 1-208-332-2100

SIF 2-01