

RESOLUTION #2004-03

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, RESCINDING RESOLUTION #2003-13

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, and;

WHEREAS, Boise County encourages its employees to maintain the highest level of auto safety so as to not only safeguard the health and welfare of employees, but that of citizens. To accomplish this goal each Boise County department shall develop procedures/standards for maintenance, safety, and driver conduct; including but not limited to mileage logs, cell phone use, passengers, and eating.

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.

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 immediately report the accident, first to local Law Enforcement, and thereafter on the County's "Property/Liability Notice of Incident" form. When local Law Enforcement is contacted regarding an injury or property damage accident it will be the discretion of the local Law Enforcement agency to investigate the accident or contact an outside agency for investigation.

The County's "Property/Liability Notice of 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 County's "Property/Liability Notice of Incident" form to the County Risk Manager for appropriate claim processing with the County's insurance carrier. A copy of County's "Property/Liability Notice 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.

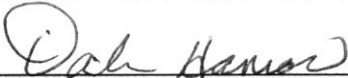
FURTHER BE IT RESOLVED, that the following Record Keeping System be set and adopted by the Boise County Board of Commissioners:

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 6th day of January 2007, with an immediate effective date.


BOARD OF BOISE COUNTY COMMISSIONERS



Dale A. Hanson, Chairman of the Board

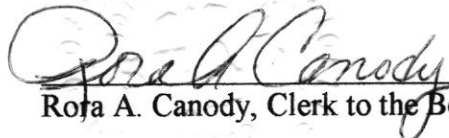


Roger B. Jackson, Commissioner



Fred H. Lawson, Commissioner

Attest:



Rofa 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? _____ AM
PM

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



NOTICE OF LOSS/ACCIDENT

TYPE OF LOSS -	AUTO <input type="checkbox"/>	LIABILITY <input type="checkbox"/>	PROPERTY <input type="checkbox"/>
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INSURED		CLAIM NUMBER
ZIP	PERSON TO CONTACT	PHONE

LOSS DATE AND TIME	AM PM	LOCATION
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DESCRIPTION OF LOSS

MOTOR VEHICLE ACCIDENT

OWNER VEHICLE: YEAR, MAKE, MODEL	LICENSE NUMBER	VIN (VEHICLE IDENTIFICATION NUMBER)	
DRIVER'S NAME AND ADDRESS		DEPARTMENT	
RIVER'S LICENSE NUMBER	DRIVER'S AGE	RESIDENCE PHONE ZIP ()	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) <input type="checkbox"/>	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 <input type="checkbox"/> NO <input type="checkbox"/>	POLICE AGENCY	CHARGES?	INVESTIGATING OFFICER	Report Number
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LIABILITY

ALLEGED OFFENCE	OFFICIALS INVOLVED		
CLAIMANT - NAME AND ADDRESS	RESIDENCE PHONE ()	BUSINESS PHONE ()	

REMARKS

DATE	REPORTED BY	REPORTED TO	SIGNATURE
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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.

E m p l o y e r	Employer's name _____		Employer status	
	Address _____		<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> Public <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other	
	City _____ State _____ ZIP _____		Is injured worker a Corporate Officer, Partner, LLC Member, or the Sole Proprietor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Employer's location address (if different) Address _____		If a Sole Proprietorship, is the injured worker a household member? <input type="checkbox"/> Yes <input type="checkbox"/> No	
City _____ State _____ ZIP _____				
Policy number _____		Organization code _____		
E m p l o y e e	Employee's last name _____			State where hired _____
	Employee's first name _____ M.I. _____			Occupation _____
	Address _____			Employment status _____
	City _____ State _____ ZIP _____		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	
	Phone # _____		Social Security # _____	
	Date of birth _____		Date Hired _____	
	Under what class code were wages reported? _____		Injury date _____	
	Regular department _____		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/> Married <input type="checkbox"/> Separated	
W a g e s	Wage rate \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other		Hours worked per week _____	
	# of days worked per week _____		Full pay for the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If board, lodging, or other advantages furnished in addition to wages, give estimated value per week. \$ _____		Did salary continue? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If gratuities (tips, etc.) were received in the course of employment, give estimated value per week. \$ _____			
A c c i d e n t o r E x p o s u r e	Place of accident or exposure (address) _____			City/State _____
	County _____		Did injury/illness occur on the employer's premises <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Time injury occurred <input type="checkbox"/> AM <input type="checkbox"/> PM		Time employee began work <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Date last worked _____		Date employer notified _____	
	Date returned to work _____		Date disability began _____	
	Part of body affected _____		Injury type (strain, cut, etc) _____	
	Injury reported to (name and phone #) _____		Body part injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If accident was caused by any person or business other than the injured worker, co-worker or the employer, please identify _____		Was it used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Were other workers also injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List other workers' names _____				
M e d i c a l	Physician or hospital (name and address) _____		<input type="checkbox"/> No medical treatment	
			<input type="checkbox"/> Minor by Employer	
		<input type="checkbox"/> Minor - clinic/hospital		<input type="checkbox"/> Emergency care
		<input type="checkbox"/> Anticipated major med/lost time		<input type="checkbox"/> Hospitalized overnight
Did anyone witness the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide name, phone # _____				
Preparer's name and title _____				
Preparer's Phone Number _____			Date Prepared _____	