Jones Petroleum

Memo

Re: Workers Comp – Injured Employee (AL/SC)

DURING INCIDENT ASSESSMENT:

1. **IMMEDIATELY** after an injury occurs, the employee is required to notify the immediate supervisor and store manager on duty**. **Treatment must be offered and ensure DAY OF INCIDENT****
2. Access the injury and determine if treatment is needed. IF the nature of the **injury is serious and requires immediate care**, the injured employee may seek treatment at the nearest walk-in clinic or urgent care. Employees should only go to the ER if the injury is life threating or after hours for clinic/urgent care. (Consult your panel of approved Doctors). Notify the HR department as soon as possible (770-775-2386)
3. **A mandatory drug and alcohol** screen is required for **ALL** worker comp injuries and should be completed at the treatment facility (**Drug test within 8hrs and Alcohol within 3hrs of incident**)
4. Fill out Workers Comp packet (for Manager & Injured). If the injury is **not life threatening** this should be completed **BEFORE** they seek treatment. The employee needs to take a copy of the First Report of Injury to the physician. Should the injury be life threatening have the employee portion filled out as soon as possible. The manager still needs to complete the First Report of Injury immediately.
5. Send completed packages to hr@jonespetroleum.com – Please note that this is a First Report of Injury with the employee's name.

FOLLOWING THE INCIDENT/TREATMENT:

1. Employees must provide documentation of doctors visit & determination – either Full Release WITH NO RESTRICTIONS or treatment plan for submission to the Worker Comp Carrier.
2. If not released within 6days, the manager must provide **13 weeks or employee timecards to submit to Carrier** (not including week of injury) **copy of the schedule** including the day of the injury.

- ***Any time someone is injured the packet must be completed.***
- ***Including when no medical treatment is required.***
- ***All injuries are to be treated by Panel Physician.***
- ***All injuries reported to management must be handled as outlined above.***

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
5. Physical Address 1	10. Mailing Address 1
6. Physical Address 2	11. Mailing Address 2
7. City 8. State 9. Zip	12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name Federated Mutual Insurance Company	21. Filing Office Name
19. Insurer Federal ID Number	22. Mailing Address 1 PO Box 486
	23. Mailing Address 2 or Telephone Number
20. Type Insurer Ins Co ☒ Self-Insurer ☐ Group Fund ☐	24. City Owatonna 25. State MN 26. Zip 55060
	27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name	32. Employee ID Number
29. Middle Name	33. Type Employee ID Number
30. Last Name	SSN ☐ Passport Number ☐ Green Card ☐
31 Last Name Suffix (ie. Jr., Sr., III)	Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐	41. Date of Birth 42. Nbr of Dependents
43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐		44. Date Hired
45. Occupation Description		46. Number of Days Worked Per Week
47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐	

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐
56. Site Address 57. City 58. State 59. Zip 60. County	62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment First Aid By Employer ☐ No Medical Treatment ☐ Emergency Room ☐ Minor Clinic / Hospital ☐ Hospitalized > 24 Hours ☐ Hospitalized Overnight ☐ Outpatient Treatment ☐	68. Name of Treatment Facility 69. Address 70. City 71. State 72. Zip	
73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name 79. Last Name 80. Title	81. Preparer's Telephone Number

03/01/2006

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work-related injuries, illnesses, – *no matter how minor*. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury? ❑ Yes ❑ No When did you tell your supervisor? Date: Time:	
Date of injury:	Time of injury:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury. (Continue on the back if necessary):	
What could have been done to prevent this injury?	
What parts of your body were injured?	
Did you see a doctor about this injury/illness? ❑ Yes ❑ No If yes, when: Date Seen:	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? ❑ Yes ❑ No	
If yes, when?	Supervisor:
Your signature:	Date:

Supervisor's Accident Investigation Form

Name of Injured Person _____

Paylocity Badge ID #_____ Store Number _____

Date of Hire _____

(Check one) ☐ Male ☐ Female

Photos Taken? ☐ Yes ☐ No Photos Attached? ☐ Yes ☐ No

What part of the body was injured? Describe in detail. _____

_____

What was the nature of the injury? Describe in detail. _____

_____

_____

Describe fully how the accident happened. What was the employee doing prior to the event? What equipment and/or tools being using? _____

_____

_____

Names of all witnesses:

_____ _____

_____ _____

Date of Event _____ Time of Event _____

Exact location of event: _____

What caused the event? _____

_____

_____

Were safety regulations in place and used? If not, what was wrong? _____

_____

Employee went to doctor/hospital? Doctor's Name _____

Hospital Name _____

Recommended preventive action to take in the future to prevent reoccurrence.

_____

_____

_____

_____ _____

Supervisor Signature Date

****HR -prior to sending FROI make sure you run Employee Summary Report and attach****

Incident Report

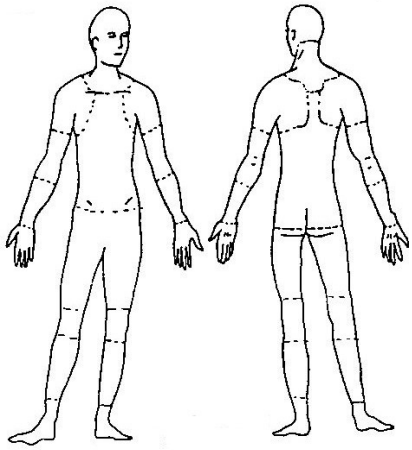
Instructions: Supervisor completes this form as soon as possible after an incident that results in any injury.

This is a report of a: ❑ Death ❑ Lost Time ❑ Dr. Visit Only ❑ First Aid Only	
Date of incident:	This report is made by: ❑ Employee ❑ Supervisor

Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: ❑ Male ❑ Female	Age:
Location:	Job title at time of incident:	

Part of body affected: (shade all that apply)



Nature of injury: (most serious one)
- ❑ Abrasion, scrapes
- ❑ Amputation
- ❑ Broken bone
- ❑ Bruise
- ❑ Burn (heat)
- ❑ Burn (chemical)
- ❑ Concussion (to the head)
- ❑ Crushing Injury
- ❑ Cut, laceration, puncture
- ❑ Hernia
- ❑ Illness
- ❑ Sprain, strain
- ❑ Damage to a body system:
- ❑ Other _____

This employee works:
- ❑ Regular full time
- ❑ Regular part time
- ❑ Seasonal
- ❑ Temporary

Months with this employer

Months doing this job:

Step 2: Describe the incident

Exact location of the incident:	Exact time:

What part of employee's workday? ❑ Entering or leaving work ❑ Doing normal work activities. ❑ During meal period ❑ During break ❑ Working overtime ❑ Other_____

Names of witnesses (if any):

What personal protective equipment was being used (if any)?

Describe step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials, and other important details.

Description continued attached sheets: ❑

Step 3: Why did the incident happen?	
Unsafe workplace conditions: (Check all that apply) ❑ Inadequate guard ❑ Unguarded hazard ❑ Safety device is defective. ❑ Tool or equipment defective ❑ Workstation layout is hazardous. ❑ Unsafe lighting ❑ Unsafe ventilation ❑ Lack of needed personal protective equipment. ❑ Lack of appropriate equipment / tools ❑ Unsafe clothing ❑ No training or insufficient training ❑ Other: _____	Unsafe acts by people: (Check all that apply) ❑ Operating without permission ❑ Operating at unsafe speed ❑ Servicing equipment that has power to it ❑ Making a safety device inoperative ❑ Using defective equipment ❑ Using equipment in an unapproved way ❑ Unsafe lifting ❑ Taking an unsafe position or posture ❑ Distraction, teasing, horseplay ❑ Failure to wear personal protective equipment. ❑ Failure to use the available equipment / tools. ❑ Other: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Have there been similar incidents prior to this one?	❑ Yes ❑ No

Step 4: Who completed and reviewed this form? (Please Print)	
Written by: Department:	Title: Date:
Notes:	
Reviewed by:	Title: Date: