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.***

S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Jones Petroluem Company
264 Alabama Blvd
Jackson GA 30233

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
Same

LOCATION #

INDUSTRY CODE | EMPLOYER FEIN

PHONE #
770-775-2386

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)
Federated Mutual Insurance Co
PO Box 486
Owatonna, MN 55060-0486
Phone: 888-333-4949
Fax: 866-636-8660
Email: pcclaims@fedins.com

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ Male
☐ Female
☐ Unknown

MARITAL STATUS
☐ Unmarried/Single/Divorced
☐ Married
☐ Separated
☐ Unknow

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

NCCI CLASS CODE

PHONE | # OF DEPENDENTS

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM (☐) CANNOT BE DETERMINED ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED
DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

0 ☐ No Medical Treatment
1 ☐ MINOR: BY EMPLOYER
2 ☐ MINOR CLINIC/HOSP
3 ☐ EMERGENCY CARE
4 ☐ HOSPITALIZED > 24 HOURS
5 ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YYYY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

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

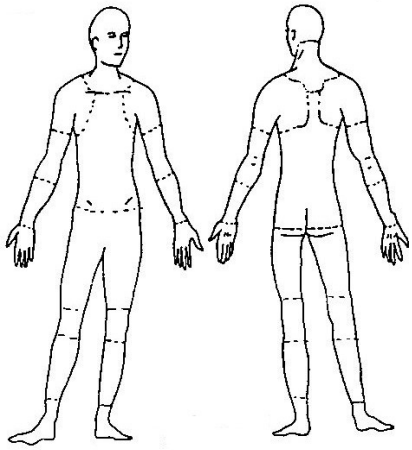
Instructions: Supervisor completes this form as soon as possible after an incident that results in any injury.

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: