10.01 EMPLOYEE RESPONSIBILITIES AND REPORTS.

Employees are responsible for conducting their work activities in a manner that is protective of their own health and safety, as well as those of other employees. Supervisors are responsible for observing and reporting employee work activities that might be deemed unsafe to the employees or others.

After consultation with the Department Head or Elected Official, Human Resources may require an employee to obtain a fitness for duty evaluation of his or her ability to perform essential functions and/or operate equipment or vehicles safely. Such a fitness for duty evaluation may be required only if the Department Head/Elected Official or supervisor has a direct observation and a reason to believe that an employee is incapable of safe operation of assigned equipment or vehicles and is a threat to the health and safety of themselves or others. The county will pay for required fitness for duty evaluations.

An employee must report every on-the-job accident, no matter how minor, to his or her supervisor within 24 hours. The supervisor is responsible for filing a written accident report immediately with the Elected Official or Department Head in charge, who must forward the report to Human Resources, who in turn notifies the county's workers' compensation insurance carrier not later than the next business day.

An employee must report every on-the-job accident, no matter how minor, to his or her supervisor within 24 hours. The supervisor is responsible for filing a written accident report immediately with the elected official or department head in charge, who must forward the reports to Human Resources, who shall also provide the information to the Health and Safety Office. The County Auditor's Office shall make regular reports to the Commissioners Court concerning on-the-job accidents and immediately report any serious or unusual incidents. Failure to report an on-the-job injury, no matter how minor, is grounds for disciplinary action.

1. Employees must immediately seek proper first aid treatment for all on-the-job injuries, including minor injuries, and must immediately report all injuries to their supervisor unless emergency circumstances exist.

Failure to report an on-the-job injury, no matter how minor, will result in disciplinary action.

10.02 ON-THE-JOB INJURIES.

Medical Attention.

It is the responsibility of the Department Head or Elected Official to notify Human Resources when an employee who sustains a bona fide, on-the-job, work-related injury. Human Resources will provide the department information to obtain medical attention from a medical facility or professional that accepts Work Comp claims and is approved by Texas Workers Compensation Commission (TWCC); except in the case of an emergency injury when the employee or his/her representative shall notify Human Resources as soon as practical following the receipt of emergency attention. The county encourages employees to return to work as soon as they are able to do so. An employee returning to work must submit a physician's statement of medical condition and release to return to work to the Department Head or Elected Official and copy to Human Resources. As determined by the Commissioners Court, at the county's expense, an employee may be required to submit to examination by an independent physician.

11.01 DRUG AND ALCOHOL TESTS.

Employees who operate vehicles or equipment that require possession of a commercial driver's license or who occupy safety sensitive positions (including EMS staff, R&B staff, deputies, investigators, jailers, and dispatchers with the Sheriff's Office) are subject to five types of testing for both drugs and alcohol: pre-employment, post-accident, random, reasonable suspicion, and return to duty. All other county employees are subject to four types of testing: pre-employment, post-accident, reasonable suspicion, and return to duty.

Post-accident Testing. The county will test an employee involved in any accident, no matter how serious, for drug and alcohol use. Forms are available and may be obtained from Human Resources.

If a covered employee fails a drug or alcohol test, the county may terminate the employee immediately, in which case the county will inform the employee where he/she can obtain help.

AUSTIN COUNTY
Accident/Incident Report

Today's Date: ____/____/____ **(Appendix A1) APR. 03**

The original Accident /Incident Report must be submitted to Human Resources within 24 hours.

Date of Injury: ____/____/____ Date of Incident: ____/____/____ No Injury: ____ *(please check)*	Date Reported to Supervisor: ____/____/____

Date of Hire: ____/____/____ Department Phone Number: ____/____/____

Department Head / Elected Official *(print name)*: _____

Name of Employee: _____ Last First Mi. **Job Title:** _____ **Department:** _____	**Work Schedule:** ___ 8am - 5pm M-F ___ 7am - 3:30pm M-F Other _____	**Sex:** ❑ M ❑ F	**Date of Birth:** _____ **Age:** _____
Home Address: _____ _____ City State Zip **Phone #:** ____/____/____ **Phone #:** ____/____/____ (cell)			**Social Security #:** ____-____-____
Employee ID #: **(on your check stub)** _____	**Employee was Working:** ❑ Alone ❑ with Fellow Workers	**Employment Category:** ❑ Full Time ❑ Part Time	**Time and Day of Accident:** ❑ _____A.M. ❑ _____P.M. S M Tu W Th F Sa day of week (circle)
Experience in Occupation at Time of Accident: ❑ Less than 1 month ❑ 1-5 months ❑ 6 months to 1 year ❑ 1-4 years ❑ 5 or more years	**Physician** ***(Name and Address)*:** _____ _____ _____ Phone: ____/____/____	**Hospital / Care Center** ***(Name and Address)*:** _____ _____ _____ Phone: ____/____/____	

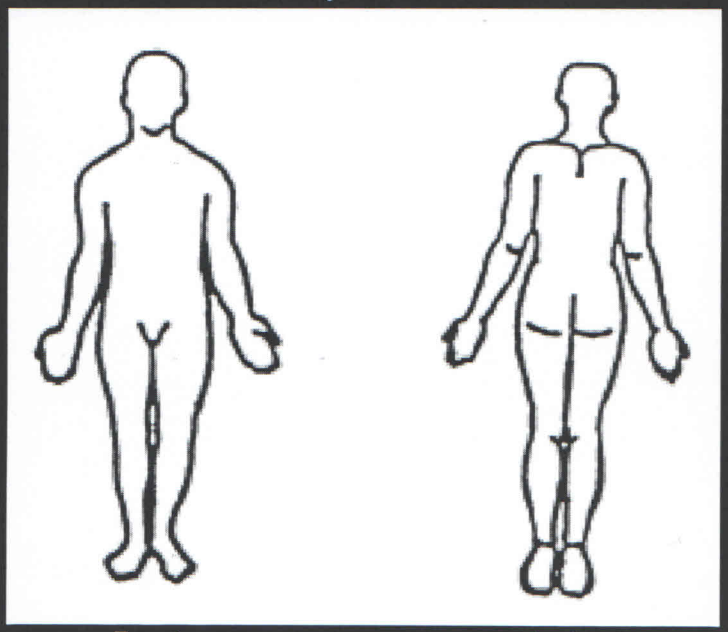
Location of Accident / Incident *(any description or address):*	**Phase of Employee's Workday at Time of Injury / Incident:**
_____ _____ ❑ happened Indoor ❑ happened Outdoor	❑ During break period ❑ Entering or leaving the building ❑ Performing work duties ❑ Working overtime ❑ During lunch period ❑ Other (explain below)

Employee's Supervisor at time of Accident: Witnessed Accident? ❒ yes ❒ no	**Probable Recurrence:** ❒ Frequent ❒ Occasional ❒ Rare	**Loss Severity Potential:** ❒ Major ❒ Serious ❒ Minor

PART of BODY INJURED or AFFECTED (Please check (√) all that apply to the injury / incident)

❑ Right Side	❑ Jaw	❑ Abdomen	❑ Throat	❑ Wrist	❑ Ankle	❑ Skin ❑ Finger Nail
❑ Left Side	❑ Ear	❑ Upper Back	❑ Shoulder	❑ Hand	❑ Thigh	❑ Toe Nail
❑ Eye	❑ Neck	❑ Lower Back	❑ Upper Arm	❑ Finger	❑ Foot	❑ No Body Injuries
❑ Nose	❑ Spine	❑ Pelvis	❑ Elbow	❑ Hip	❑ Toe	❑ Other
❑ Mouth	❑ Chest	❑ Head/ Scalp	❑ Forearm	❑ Knee	Describe Other: _____	

Circle Injured Area



Front **Back**

NATURE of INJURY or ILLNESS (Please fill in the blanks and check (√) all that apply to injury / incident)

❑ Puncture	❑ Bruise, Contusion	❑ Skin Disorder	❑ Amputation	❑ Muscle Sprain	❑ Cumulative Trauma Disorder	❑ Puncture
❑ Laceration	❑ Dislocation	❑ Burn	❑ Insect/Animal Bite	❑ Muscle Strain	❑ Irritation	
❑ Fracture	❑ Abrasion	❑ Respiratory	❑ Foreign Body	❑ Hernia	❑ Infection	

(Please fill in the blanks and check (√) all that apply to injury / incident)

MEDICAL ATTENTION

First aid was given by:

_____

_____

❒ No First aid required
❒ Drug tested ❒ Alcohol tested

Sent to ❒ Doctor
❒ Hospital / Care Center

NAME OF WITNESSES

(list witnesses and titles)

_____

_____

_____

_____

SEVERITY of injury / incident

❑ First Aid
❑ Medical Treatment
❑ Lost Work Days
❑ Fatality
❑ No Lost Work Days
❑ Other (specify)

(Please complete if there were witnesses to the injury / incident)

WITNESSES STATEMENTS (attach sheet for additional comments)

_____

_____

_____

_____

_____

(Please check (√) all that apply to the injury / incident)

WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED to the ACCIDENT/ INCIDENT?

❑ Close Clearance/Congestion	❑ Floors/Work Surfaces	❑ Inadequate Housekeeping	❑ Defective Tools/Equipment/Vehicle
❑ Hazardous Placement	❑ Inadequate Ventilation	❑ Equipment Failure	❑ Illumination
❑ Inadequate Warning System	❑ Equipment/Workstation Design	❑ Inadequate Guards/Barriers	❑ Inadequate/Improper PPE
		❑ Other:_____	

(Please check (□) all that apply to the injury / incident)

WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS?

- ❑ Abuse or Misuse
- ❑ Inadequate Supervision
- ❑ Inadequate Purchasing
- ❑ Inadequate Engineering
- ❑ Inadequate Maintenance
- ❑ Inadequate Tools / Equipment
- ❑ Improper Work Surfaces
- ❑ Wear and Tear
- ❑ Lack of Knowledge/Training
- ❑ Improper Motivation
- ❑ Inadequate Capacity
- ❑ Lack of Skill
- ❑ None: _____
- ❑ Other: _____
- ❑ Inadequate Surface / Grounds

(Please check (√) all that apply to the injury / incident)

WHAT ACTION or INACTION CONTRIBUTED to the ACCIDENT / INCIDENT?

- ❑ Failure to Make Secure
- ❑ Under the Influence of Drugs/Alcohol
- ❑ Failure to Warn/Signal
- ❑ Inadequate/Improper PPE Use
- ❑ Nullified Safety/Control Devices
- ❑ Used Defective Equipment
- ❑ Horseplay/Distractive Action
- ❑ Operating at Improper Speed
- ❑ Used Equipment Improperly
- ❑ Improper Lifting
- ❑ Operating Procedure Deviation
- ❑ Running/Rushing/Acting in Haste
- ❑ Improper Loading
- ❑ Unauthorized Actions
- ❑ Used Wrong Tool/Equipment
- ❑ None
- ❑ Improper Technique
- ❑ Improper Position
- ❑ Servicing/Operating Equipment
- ❑ Other_____

(Please check (√) all that apply to the injury / incident)

PREVENTIVE MEASURES (What corrective actions have been taken or are planned to prevent a recurrence?)

- ❑ Improve Enforcement
- ❑ Improve Clean-Up Procedures
- ❑ Repair/Replace Equipment
- ❑ Corrective Counseling
- ❑ Improve Storage/Arrangement
- ❑ Rotation of Employee
- ❑ Eliminate Congestion
- ❑ Improve/Change Work Method
- ❑ Identify/Improve PPE
- ❑ Install/Revise Guards/Devices
- ❑ Task Analysis to be Completed
- ❑ Task Analysis/Procedure Revision
- ❑ Improve Design/Construction
- ❑ Job Reassignment of Employee
- ❑ Use Other Materials/Supplies
- ❑ Improve Illumination
- ❑ Mandatory Pre-Job Instructions
- ❑ Improve Ventilation
- ❑ Re-instruction of Employee
- ❑ Other_____

Please complete your description as best as you can of the accident / incident)

EMPLOYEE'S DESCRIPTION of ACCIDENT / INCIDENT

(Please have Supervisor complete his/her description of the accident / incident)

SUPERVISOR'S DESCRIPTION of ACCIDENT / INCIDENT (attach sheet for additional comments)

(Supervisor and employee to complete)

SPECIFIC CORRECTIVE ACTIONS or PREVENTIVE MEASURES TAKEN

Corrective Action Taken	Person Responsible	Target Date	Date Completed

I certify that the information provided in this report is true.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action.

I hereby authorize the release of all medical records relating to the injury to my employer and insurance provider.

Employee's Printed Name	**Employee's Signature**	**Date**
Supervisor on Duty Print	**Supervisor's on Duty Signature**	**Date**
Department Head Print	**Department Head's Signature**	**Date**

RETURN ORIGINAL TO HUMAN RESOURCES

AUSTIN COUNTY Contact:

Sharon McCowin
Director, Human Resources
(979) 865-5911 ext. 2266
One East Main
Bellville, TX 77418-1521
(979) 865-3783 FAX
www.austincounty.com
smccowin@austincounty.com

WORKERS' COMPENSATION INSURANCE Contact:

Texas Association of Counties Risk Management Pool
JI COMPANIES
10535 Boyer Boulevard, Suite 100
Austin, TX 78758
p. 512-427-2349
f. 512-346-9321
www.jicompanies.com

Employee Notice of Political Subdivision Workers' Compensation Alliance (Alliance) Program Requirements

Important Contact Information

- Alliance website is www.pswca.org
- Alliance phone number is 1-866-99-PSWCA (1-866-997-7922)
- To contact your adjuster call 1-800-752-6301

Information, Instructions and your Rights and Obligations

Your employer has chosen the Political Subdivision Workers' Compensation Alliance (Alliance) to manage the health care and treatment you may receive if you are injured at work. The Alliance includes a panel of health care providers who are trained in treating work related injuries. They are also trained in getting people back to work safely.

If you are injured at work, tell your supervisor or employer immediately. The enclosed information will help you to seek care for your injury. Also, your employer will help with any questions about how to get treatment. You may also contact Texas Association of Counties via JI Specialty Service for any questions about your care and treatment for a work related injury. The Fund and your employer have formed a team to provide timely health care for injured workers. The goal is to provide quality medical care and return you to work as soon as it is safe to do so.

Injured employees' Rights and Obligations...

What to do if you are injured while on the job...

If you are injured while on the job, tell your employer as soon as possible. A list of Alliance treating doctors may be available from your employer. A complete list is also available online at http://www.pswca.org or, you may contact your adjuster directly at the following address and/or toll-free telephone number:

JI Specialty Services
P.O. Box 160120 Austin, TX 78716
800-752-6301

In case of an emergency…

If you are hurt at work and it is a life-threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours, you should go to the nearest care facility.

Emergency care does not need to be approved in advance. "Medical emergency" is defined in Texas laws. It is a medical condition that comes up suddenly. There are acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

Non-emergency care…

Once you have selected your treating doctor, you will need to notify your adjuster of your selection by calling and advising them or you can complete the "Treating Doctor Selection Form" pool JI2 form and submit to your adjuster.

Complaints

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of the operation. This includes a complaint about the Alliance or an Alliance doctor. It may also be a general complaint about the PSWCA Direct Contracting Program.

A complainant can notify the PSWCA Direct Contracting Program Grievance Coordinator of a complaint by phone or in writing via mail or fax. Complaints should be forwarded to:

PSWCA Direct Contracting Program
Attention: Grievance Coordinator
P.O. Box 763 Austin, TX 78767
1-866-99-PSWCA (1-866-997-7922)
E-mail: customerservice@pswca.org

Employee Acknowledgment of PSWCA Direct Contracting Program

I have received information that informs me of my employer's relationship with the Alliance and how to get health care if I suffer a work related injury/illness.

If I am injured on the job, I understand that:

1. I must choose a treating doctor from the list of doctors provided by my employer or obtain the list myself which is located at **www.pswca.org**
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. JI Specialty Services for Texas Assn of Counties will pay the treating doctor and other referral providers.
4. I may be required to pay for health care received from a provider if that provider is not on the approved list.
5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
6. Additional information regarding the PSWCA is available on my pool's website at www.county.org

_____ _____
Signature Date

_____
Printed Name

I live at: _____
Street Address

_____
City State Zip Code

Name of Employer: _____

Call 800-752-6301if you need assistance locating a treating provider.

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: ____ /____ /____)

PLEASE RETURN THIS FORM TO YOUR EMPLOYER
DO NOT RETURN THIS FORM TO JI SPECIALTY SERVICE UNLESS REQUESTED

Important Contact Information

- Alliance website is www.pswca.org
- Alliance phone number is 1-866-99-PSWCA (1-866-997-7922)

To contact JI Specialty Service call 800-752-6301