**Agency Name**

**Transit Policies and Procedures**

|  |  |
| --- | --- |
| **Subject** | Injury on the Job |
| **Section** | Safety |
| **Effective Date** |  |
| **Approved By** |  |
| **Approval Date** |  |

**Purpose**

Provide instructions for employees who sustain injuries while on duty.

**Definitions**

*Injury:* Damage to the body caused by external forces such as accidents, falls, hits, or weapons.

**Procedure**

Develop safety practices for preventing on-the-job injuries. Require employees to participate in safety training and instruct them to report all unsafe practices or conditions to the Transit Director. Expect employees to know and adhere to all safety procedures for their assigned work activities. Provide personal protective equipment (PPE) and require employees to use it when appropriate. Replace PPE when it gets damaged.

Employees should use the following procedure when an on-the-job injury occurs:

* Notify emergency services for injuries requiring immediate medical attention.
* Promptly report work-related injuries to the Transit Director.
* Complete an incident report form and submit it to the Transit Director.

The Transit Director shall provide the Safety Officer with a copy of all documentation pertaining to on-the-job injuries within 48 hours of the injury. The Safety Officer shall review the documentation and make recommendations for action items to prevent future injuries.

**Responsibilities**

It is the responsibility of all employees to practice safety procedures to prevent on-the-job injuries. If injuries occur, the affected employee is responsible for notifying emergency services (if applicable) and the Transit Director. The employee is also responsible for submitting an incident report form. The Transit Director is responsible for requesting a safety investigation and for providing all appropriate files. The Safety Officer is responsible for reviewing the incident report and recommending action items.

**Example**

See attached template.

**INCIDENT/INJURY REPORT FORM**

Date Report Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Report No. \_\_\_\_\_\_\_\_\_\_

Time Report Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

DATE OF INCIDENT / INJURY: \_\_\_\_\_\_\_\_\_\_\_\_ TIME: \_\_\_\_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ VEHICLE NO. \_\_\_\_\_\_\_\_\_\_

LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF INJURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER / HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAY-DURING OFFICE HOURS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

WAS INCIDENT / INJURY REPORT TO:

YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ DRIVER

YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ OFFICE STAFF

YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ SUPERVISOR

YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ POLICE

YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ MEDICAL

YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIPTION OF ACCIDENT / INCIDENT:

INJURIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DID INJURED PERSON REQUIRE HOSPITAL TREATMENT? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, NAME OF HOSPITAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW WAS INJURED TRANSPORTED? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF AMBULANCE, NAME OF SERVICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF HOSPITAL TREATMENT WAS NOT NECESSARY, DID INJURED RECEIVE MEDICAL TREATMENT AT DOCTOR’S OFFICE?

YES \_\_\_\_\_ NO \_\_\_\_\_

NAME OF PERSON FILLING OUT REPORT (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PERSON FILLING OUT REPORT (sign): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_