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): _____