Grand County
125 East Center Street
Moab, Utah 84532
435-259-1321

ACCIDENT REPORTING PROCEDURES

The following forms are provided to elected officials, department heads and supervisors as a guide for reporting workplace injuries, accidents and property damage incidents. Please make copies as needed. If you have any questions or need additional forms please contact the Risk Manager.

Immediately following ANY accident you must notify the County Risk Manager of any workplace injury, accident or property damage and submit the following completed forms to the Risk Manager:

Post-Accident Drug Testing: All employees involved in an accident and/or workplace injury resulting in injury, fatality, or damage to property shall submit a sample for drug testing ***within four (4) hours*** at the designated testing facility (specified on the Chain of Custody form). The employee must stay in the company of a supervisor or other authorized personnel, and should take the attached Chain of Custody form located in the packet when reporting for any post-accident drug test.

Employee Workplace Injuries: All workplace employee injuries shall be reported **immediately** to the Risk Manager. Supervisors will ensure that the Employee Written Statement and the Witness Written Statements are completed and returned to the Risk Manager within eight (8) hours, or by the next business day if incident occurs during the weekend. The Injury Incident Investigation Form (and Property Damage Investigation Form, if applicable) must be completed by the supervisor and returned to the Risk Manager within 72 hours.

If the injury requires medical attention, the supervisor or designated personnel must accompany the injured worker to a physician. If the injury is of a serious nature or is after hours and requires emergency medical attention the employee should be taken directly to the Moab Regional Hospital emergency room. The Insurance information sheet should be submitted to the medical facility providing treatment.

Auto Accidents: **All** motor vehicle accidents shall be reported to the Risk Manager immediately, including accidents without personal injury. ***Notify dispatch and have a law officer other than Grand County investigate the accident and take pictures***. Supervisors will ensure that employees involved in the accident complete the Auto Accident Report Form (contained in the Trust Packet in each County fleet vehicle), the Employee Written Statement, and Witness Written Statements, and submit these to the Risk Manager within eight (8) hours. All other supervisor investigation forms contained in this packet, must be completed and returned to the Risk Manager within 72 hours, along with any photos and/or law enforcement reports.

Property Damage: For any incident resulting in damage to County property, or damage to non-County property caused by a County employee, supervisors will ensure that Employee Written Statement and the Witness Written Statements are completed and returned to the Risk Manager within eight (8) hours, or by the next business day if incident occurs during the weekend. Within 72 hours, the supervisor will submit the Property Damage Investigation Form, pictures of damage, law enforcement reports if available, and two (2) estimates of repair.

- Property Damage Investigation Form
- Insurance Contact Information

Forms attached:

- Chain of Custody & Lab Drug Test Requisition Form
- Employee Written Statement
- Witness Written Statement
- Injury Incident Investigation Form

Risk Manager:

Personnel Services Director
125 E. Center Street
435-259-1323 (Office)
gchr@grandcountyutah.net

Revised 06/2024

For post accident testing, report to the testing center immediately following the accident.

Take prescription medication you are currently using with you to the testing center.

GRAND COUNTY

CHAIN OF CUSTODY & LABORATORY DRUG TEST REQUISITION FORM

Step 1: (To Be Completed by Employer or Collector)

A. Employer Information

Grand County
125 E Center Street
Moab, Utah 84532
435-259-1378

B. Collector Information

Elwood Staffing AFTER HOURS:
550 N. Main St. Moab Regional Hospital
Moab, Utah 84532 450 W. Williams Way
435-259-7837 Moab, Utah 84532
Hours 8:30 am to 3:30 pm 435-719-3500

C. MRO Information

Intermountain Drug Testing AFTER HOURS:
P.O. Box 9800 Moab Regional Hospital
Salt Lake City, Utah 84109 450 W. Williams Way
801-486-5400 Moab, Utah 84532
435-719-3500

D. Donor Information

Name: _____ Phone: _____

Address: _____ SSN: _____

_____ **PLEASE PRINT LEGIBLY**

E. Reason for Test: Reasonable Suspicion Post Accident Other/Explanation: _____ **F. Specimen Type:**

Urinalysis Blood Urinalysis & Blood

Step 2: To Be Completed by Donor

I hereby consent to the collection of my specimen and its analysis for drugs of abuse. I certify that I have not adulterated my specimen in any way, that the information I provided on this form is correct, and that the specimen(s) collected were sealed in my presence. I authorize the release of the results of this testing to my employer, prospective employer, or my employer's authorized personnel.

_____

_____ Donor Name (Print) Donor Signature Date

Step 3: Completed by Collector

I certify that the donor's identification has been positively verified by the means indicated below and that the specimen identified on this form is the specimen collected, labeled, and sealed in the donor's presence. I hereby release this specimen for transport to the laboratory.

I D verified by: Photo Employer Rep Other_____

_____

_____ Collector Name (Print) Collector Signature Date

Step 4: Completed By Laboratory

I certify that the specimen received with this form was sealed in the appropriate container with the seal intact, and the identification number and/or name on this form matches that on the specimen, and the specimen was transferred to temporary laboratory storage.

Yes No Remarks_____

_____

Accessioner (Print) Accessioner Signature Date

Accession No. _____

Employee Written Statement

Written Statement of:

_____ DOB:

_____ SS#: _____

Date of Statement: _____

Date of Incident: _____

Location of Incident: _____

Witnesses: _____

Occurrence:

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Employee Signature:

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_ Date

Revised 6/5/08

Witness Written Statement

Date of Accident Witnessed: _____

Name of Witness: _____

Address: _____

Phone #: _____

Number of Witness: _____

Date Witness Completed: _____

STATEMENT OF WITNESS

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(If additional space is needed, please use backside).

Witness Signature: _____

Supervisor Signature: _____

CONFIDENTIAL

INJURY INCIDENT INVESTIGATION FORM OSHA Case#_____

*This form to be completed by the supervisor. All reports must be signed by the supervisor and the employee and returned to the Risk Manager **within 72 hours** of the incident.*

INCIDENT OVERVIEW

Employee Name:_____ Department: _____ Incident Date: ____/____/____ Incident Location/Address:_____ Time of Incident:_____:_____ **am** / **pm** Was a post-accident drug-test administered? ☐**Yes** ☐**No**

DESCRIBE HOW THE INCIDENT OCCURRED (BE SPECIFIC. If necessary, include photos/sketches of the scene):

_____

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_____

___ Chemicals, materials, or substances involved:_____

IN REVERSE ORDER, DESCRIBE THE INJURY EVENT AND THE EVENTS LEADING UP TO THE INCIDENT.
(Starting with the injury and moving backward in time, reconstructing the sequence of events leading up to the injury.) Injury Event:_____

Preceding Event #1:_____ Preceding Event #2:_____

Preceding Event #3, 4, etc.:_____

_____

___

EMPLOYEE WORK SCHEDULE

Normal days per week:_____ Normal hours/shift worked per day:_____

Hours worked in week up to time of incident: _____ Time shift began on date of incident:_____:_____ **am** / **pm** Did Employee return to work? ☐**YES** (return date)____/____/____ (time) ____:_____ **am** / **pm** ☐**NO** Employee has NOT returned to work Total work time missed due to injury: _____(hours)_____(days)

INJURY INFORMATION

DESCRIBE THE INJURY (BE SPECIFIC. Describe parts of body, nature of injury, extent of pain. If needed, draw a picture):

_____

___

_____

___

_____

___ Did Employee have a prior injury or pre-existing condition? ☐**Yes** ☐**No** Please describe:

_____

TREATMENT INFORMATION

Was First Aid administered on-site? ☐**Yes** ☐**No** Please describe: _____

_____

___ Was Employee Treated in the Emergency Room? ☐**Yes** ☐**No** ER Physician:_____ Was an ambulance used? ☐**Yes**

☐**No** Was Employee hospitalized overnight? ☐**Yes** ☐**No** Length of stay in hospital:_____

CONFIDENTIAL

INJURY INCIDENT INVESTIGATION FORM OSHA Case#_____

TREATMENT INFORMATION (CONTINUED)

Did the Employee see a physician, chiropractor, or other medical professional? ☐**Yes** ☐**No**

Physician Name:_____ Hospital/Clinic Name:_____

Date of first visit:____/_____/_____ Date of follow-up visit:_____/_____/_____

Medication Perscribed:_____ Work Restrictions: ☐**FULL** Anticipated time lost from work: _____

☐**PARTIAL** Please describe all restrictions: _____

FACTORS CONTRIBUTING TO CAUSE THE INCIDENT (Check all that apply):

Actions:	**Conditions:**	**Management**
[ ] Failure to follow policy / training	[ ] Poor workstation design or layout	[ ] Lack of written procedures
[ ] Horseplay	[ ] Congested work environment	[ ] Rules not enforced
[ ] Operating equipment without authority [ ] By-passing safety device	[ ] Hazardous substance present	[ ] Hazards not identified
[ ] Using equipment improperly	[ ] Fire or explosion hazard	[ ] Insufficient worker training
[ ] Using defective equipment	[ ] Improper tool or equipment used	[ ] Inadequate supervisor training
[ ] Servicing equipment while in use	[ ] Insufficient guards / safety interlocks [ ] Slippery conditions	[ ] Inexperience of employee
[ ] Failure to properly use PPE	[ ] Defective tools, equipment, materials [ ] Restricted motion	[ ] Insufficient maintenance
[ ] Inattentiveness	[ ] Inadequate lighting / Ventilation	[ ] Insufficient supervision
[ ] Under the influence	[ ] Excessive noise	[ ] Unsafe design (engineering)
[ ] Safety Rule violation	[ ] Poor house keeping	[ ] Inadequate supervision
[ ] Improper lifting	[ ] High or low temperature	[ ] Inadequate work standards
[ ] Unsafe acts of others	[ ] Other:	[ ] Unrealistic scheduling
[ ] Other:		[ ] Other:

Explain:

ROOT CAUSES: (Identify all root causes of this incident)

_____

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_____

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_____

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Possibility of incident happening again: ☐**High** ☐**Moderately High** ☐**Average** ☐**Low** ☐**Unlikely**

CORRECTIVE ACTIONS	**Issued To**	**Due Date**	**Completed**

******Attach additional pages as necessary. Page_____ of _____******

Investigating Supervisor:_____ Date: ___ /___ /___ Employee:_____ Date: ___ /___ /___ Safety Manager: _____ Date: ___ / ___/ ___

PROPERTY DAMAGE INVESTIGATION FORM OSHA Case#_____ *This form to be completed by the supervisor. All reports must be signed by the supervisor and the employee and returned to the Risk Manager* ***within 72 hours*** *of the incident.*

INCIDENT OVERVIEW

Employee Name:_____ Department: _____ Incident Date: ___/___/___ Incident Location/Address:_____ Time of Incident:_____:_____ **am** / **pm** Was a post-accident drug-test administered? ☐**Yes** ☐**No**

DAMAGED PROPERTY INCLUDES (Check all that apply): FLEET# (If damage occurred to County fleet vehicle):_____ [ ] Grand County property

[ ] Other property NOT owned by Grand County

DESCRIPTION OF PROPERTY DAMAGE:_____

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DESCRIBE HOW THE INCIDENT OCCURRED (BE SPECIFIC. If necessary, include photos/sketches of the scene):

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IN REVERSE ORDER, DESCRIBE THE DAMAGE EVENT AND THE EVENTS LEADING UP TO THE INCIDENT.

(Starting with the injury and moving backward in time, reconstructing the sequence of events leading up to the injury.) Damage Incident:_____

Preceding Event

#1:_____ Preceding

Event #2:_____

Preceding Event #3, 4,

etc.:_____

_____

__

PROPERTY DAMAGE INVESTIGATION FORM OSHA Case#_____

FACTORS CONTRIBUTING TO CAUSE THE INCIDENT (Check all that apply):

Actions:	**Conditions:**	**Management**
[ ] Failure to follow policy / training [ ] Horseplay [ ] Operating equipment without authority [ ] By-passing safety device [ ] Using equipment improperly [ ] Using defective equipment [ ] Servicing equipment while in use [ ] Failure to properly use PPE [ ] Inattentiveness [ ] Under the influence [ ] Safety Rule violation [ ] Improper lifting [ ] Unsafe acts of others [ ] Other:	[ ] Poor workstation design or layout [ ] Congested work environment [ ] Hazardous substance present [ ] Fire or explosion hazard [ ] Improper tool or equipment used [ ] Insufficient guards / safety interlocks [ ] Slippery conditions [ ] Defective tools, equipment, materials [ ] Restricted motion [ ] Inadequate lighting / Ventilation [ ] Excessive noise [ ] Poor house keeping [ ] High or low temperature [ ] Other:	[ ] Lack of written procedures [ ] Rules not enforced [ ] Hazards not identified [ ] Insufficient worker training [ ] Inadequate supervisor training [ ] Inexperience of employee [ ] Insufficient maintenance [ ] Insufficient supervision [ ] Unsafe design (engineering) [ ] Inadequate supervision [ ] Inadequate work standards [ ] Unrealistic scheduling [ ] Other:

Explain:

ROOT CAUSES: (Identify all root causes of this incident)

_____

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Possibility of incident happening again: ☐**High** ☐**Moderately High** ☐**Average** ☐**Low** ☐**Unlikely**

CORRECTIVE ACTIONS	Issued To	Due Date	Completed

******Attach additional pages as necessary. Page_____ of _____******

Investigating Supervisor:_____ Date: ___ /___ /___ Employee:_____ Date: ___ /___ /___ Safety Manager: _____ Date: ___ / ___/ ___

INSURANCE INFORMATION

Utah Local Governments Trust
C/O Constitution State Services
P.O. Box 173762
Denver, Colorado 80217-3762

Grand County
Personnel Services
125 E. Center Street
Moab, Utah 84532
Office Phone: 435-259-1323
gchr@grandcountyutah.net