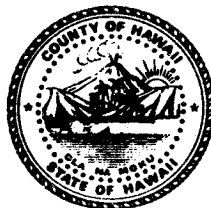


Harry Kim
Mayor



Lincoln S.T. Ashida
Corporation Counsel

Gerald Takase
Assistant Corporation Counsel

County of Hawaii

OFFICE OF THE CORPORATION COUNSEL

101 Aupuni Street, Suite 325 • Hilo, Hawaii 96720-4262 • (808) 961-8251 • FAX (808) 961-8622

February 18, 2003

MEMORANDUM 2003-1

TO: ALL DEPARTMENTS

FROM: MICHAEL KAGAMI *MK*
Deputy Corporation Counsel

RE: REPORTING OF ALL COUNTY VEHICLE/EQUIPMENT ACCIDENTS

The County of Hawai'i's policy of reporting all accidents that involve the County's vehicles (includes private or rented vehicles used for County business) and equipment and the County's employees is hereby restated for informational purposes.

IN CASE OF A VEHICLE ACCIDENT

1. Stop immediately. Do not leave the scene of the accident. Avoid obstructing traffic to the extent possible. Avoid exposure to any traffic hazard. Place emergency flags or reflectors when conditions require.
2. Call the police to report the accident.
3. If there are injured parties, call for medical attention.
4. Obtain the names, addresses, and phone numbers of the drivers involved as well as all occupants of the vehicles.
5. Obtain the names, addresses, and phone numbers of persons who may have witnessed the accident.
6. Obtain the names of the police officers who respond to the accident.

Memorandum to All Departments
February 18, 2003
Page 2

7. As soon as practicable, notify your supervisor of the accident.
8. Where there are injuries to County employees, notify the Department of Civil Service, Health and Safety Division at 961-8215. Also, fill out the Hawai'i County Incident/Accident Report form (revised 7/02), a copy of which is attached, and submit it to the Department of Civil Service, Health and Safety Division.
9. Do not admit liability or fault for the accident. Give a brief factual description of the accident to police when asked to do so.
10. Complete and submit the Hawai'i County Vehicle Accident/Property Damage Report (revised 2/03), a copy of which is attached. The report shall be completed and submitted within one working day of the accident.

MSK:ch
Enclosures

s:\dept\vehicle accident reporting\memo all depts\2-18-03\MSKch.wpd

HAWAII COUNTY VEHICLE ACCIDENT/PROPERTY DAMAGE REPORT (2/03)

Department _____ Division/Section _____

Date of Accident/Damage _____ Time _____

Location of Accident/Damage _____

Reported to police? Yes ___ No ___ Report No. _____

Photos taken? Yes ___ No ___ By _____

DRIVERS INVOLVED (use separate sheet if needed)

Employee Driver _____ Bus. phone _____

Other Drivers

Name _____

Name _____

Address _____

Address _____

Phone _____

Phone _____

Police vehicle: Subsidized? Yes ___ No ___ On Duty? Yes ___ No ___

INJURED PARTIES/WITNESSES (Indicate which applies)(use separate sheet if needed)

Name _____

Name _____

Address _____

Address _____

Phone _____

Phone _____

VEHICLES INVOLVED/DAMAGED

Describe County vehicle _____ License No. _____

Describe damage _____

Estimate: Amount _____ By _____

Describe other vehicle(s) involved

1. Make/model _____ License No. _____ Insurance Co. _____

2. Make/model _____ License No. _____ Insurance Co. _____

3. Make/model _____ License No. _____ Insurance Co. _____

COUNTY PROPERTY/EQUIPMENT DAMAGED

Describe property/equipment _____

Describe how damage occur _____

Estimate: Amount _____ By _____

PRIVATE PROPERTY/EQUIPMENT DAMAGED

Describe property/equipment _____

Describe how damage occur _____

Estimate: Amount _____ By _____

DESCRIPTION OF HOW VEHICLE ACCIDENT OCCUR (use separate sheet if needed)

DIAGRAM Use solid lines with arrows for path and direction of vehicle. Use dotted lines after impact to final resting site. Identify County vehicle with "C". Number other vehicles same as in Vehicles Involved/Damaged section. Show point of impact. Use separate sheet if necessary.

County driver/employee Date

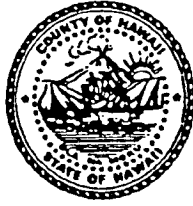
Supervisor Date

Division Head Date

Department Head Date

Distribution: Corporation Counsel (s:claims/forms2.03)
Director of Finance
Safety Department
Automotive Division

Harry Kim
Mayor



XC: All Supervisors
Michael R. Ben, SPHR
Director of Personnel

Rodney T. Kaido
Deputy Director of Personnel

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Department of Civil Service
Health & Safety Division

Aupuni Center • 101 Pauahi Street, Suite 2 • Hilo, Hawaii • 96720
Phone (808) 961-8215 • Fax (808) 961-8216
Workers' Compensation Phone (808) 961-8344 • Fax (808) 961-8416

Memorandum No. 02-13

TO: All Department and Agency Heads

FROM: Charmaine Kamaka, Personnel Program Specialist

DATE: August 26, 2002

SUBJECT: REVISED HAWAII COUNTY INCIDENT/ACCIDENT REPORT INSTRUCTIONS

Attached is a copy of the revised Hawaii County Incident Accident Report Form (Revised 07/02), along with detailed instructions for completing the form. This form replaces the form that was last revised on 10/99, and is to be used effective 09/01/02. The Hawaii County Incident/Accident Report Form (revised 07/01) is to be **completed** (by injured employee's immediate supervisor) **and submitted** for any work related accident suffered by any employee of Hawaii County, **within 3 workdays following the accident.**

This new form can be e-mailed to you, or provided on a diskette, and may be completed on the computer, or typed or handwritten manually. Please call the Safety Division at extension 8215 to request a template on a diskette or by e-mail.

Thank you.

Attachments

1. Instructions for Completing Incident/Accident Report Form
2. Incident/Accident Report Form (revised 07/02)

26031

INSTRUCTIONS FOR COMPLETING HAWAII COUNTY INCIDENT/ACCIDENT REPORT FORM

Circle "Incident" if the accident does not involve medical treatment; Circle "Accident" if the accident requires medical treatment.

1. Enter last name, first name, and middle initial of injured employee, along with injured employee's home phone number.
2. Enter injured employee's department, division, and district.
3. Enter injured employee's social security number.
4. Enter injured employee's job title or position.
5. Enter the time of the accident.
6. Enter the date of the accident.
7. Enter the date that the injured employee reported the accident to you (the supervisor).
8. If the employee is disabled from work due to the accident (other than the day of the accident), enter the first day of disability. If the employee did not lose time from work due to the accident (other than the day of the accident), enter N/A.
9. If employee has returned to work (following disability), enter the date that the employee returned to work. If the employee did not lose time from work (other than the day of the accident), enter N/A.
10. Enter the (specific) location of the accident (i.e. Hilo base yard, etc.).
11. Enter "yes" if employee continued to work on the day of the accident. Enter "no" if the employee did not continue to work on the day of the accident.
12. Enter the type of injury (i.e. cut, scrape, sprain, etc.).
13. Enter the part of the body that was injured (i.e. left knee, head, right ring finger etc.).
14. If the injured employee was seen by a physician, enter the name of the physician. If the employee did not see a physician, enter "none".
15. Enter the activity or job the employee was performing at the time of the accident (i.e. lifting desk, moving boxes, shoveling debris, etc.).
16. Enter the equipment, machine, or tools that employee was using at the time of the accident (i.e. shovel, grinder, hammer, weed-eater, grass cutter, chain saw, etc.).
17. Describe how the accident occurred (i.e. While moving 15 boxes weighing approximately 30 pounds from floor to 5 foot high shelf, experienced pain in lower back area).
18. Describe hazardous conditions that may have contributed to the accident (i.e. heavy boxes, lifting boxes above shoulder height, wet, slippery floor, etc.).
19. Enter the names and phone numbers of any witnesses. If no witnesses, enter "none".
20. Describe any measures that could have been taken to prevent this accident (i.e. get assistance from fellow employee, remove some of the contents in boxes, making boxes lighter, mop up wet floor, use caution tape or signage, etc.).

PERSONAL PROTECTIVE EQUIPMENT SECTION

Place a check mark in those columns that apply (i.e. If hard hat was issued, check box in "issued" column; if hard hat was used, check column box in "used" column. Do not check boxes for those items that were not either issued or used.

21. Describe the actions you will be taking to prevent a recurrence of this type of accident (i.e. back injury prevention training to be given to all employees, counsel employee about requesting assistance when necessary, or lightening the load prior to the lift, providing additional safety equipment, etc).
22. Injured employee to review, sign and date. Department or Division Safety Representative to review, print and sign name, and date.

Division Head to review, enter any remarks regarding the accident, and print and sign name, and date.

Department Head to review, enter any remarks regarding the accident, and print and sign name, and date.

Injured employee is to sign the medical authorization section, and date.

A copy of the Hawaii County Incident/Accident Report Form is to be forwarded to the Health and Safety **Division within 3 days of the incident/accident**. If medical treatment was rendered, a completed WC-1 must be attached to the Incident/Accident Report Form.

The original Incident/Accident Report Form must be permanently retained by the injured employee's Department.

HAWAII COUNTY INCIDENT/ACCIDENT REPORT

To be completed by injured employee's immediate Supervisor, and signed by injured employee.

Circle Incident if NO medical treatment required; Circle Accident if medical treatment required. ----- PLEASE PRINT -----			
1. Employee Name (Last, First, MI) Res. Ph. No.	2. Department / Division & District	3. Social Security No.	
4. Job Title / Position	5. Time of Incident / Accident	6. Date of Incident / Accident	
7. Date Reported	8. Date Disability Began (Did employee lose time from work, other than the day of injury?)	9. Date Returned to Work (Is employee back to work following disability?)	
10. Location of Incident / Accident	11. Did employee complete shift?	12. Nature of Injury/Illness (cut, sprain, etc.)	
13. Part of the body injured (right/left knee, etc.)	PERSONAL PROTECTIVE EQUIPMENT		
	Item	Issued	Used
14. Treating Physician (Write "None" if no medical treatment provided)	A. Hard Hat		
	B. Safety Glasses		
	C. Goggles		
	D. Face Shield		
15. What was employee doing at the time of the incident/accident?	E. Ear Muff		
	F. Respirator		
	G. Clothing (Type)		
	H. Gloves		
16. What equipment, machine or tools were being used?	I. Foot Protection		
	J. Other (Description)		
17. How did the incident/accident occur? Describe in detail the events that led to the accident.			
18. Describe any hazardous conditions, items or practices which contributed to the incident/accident.			
19. Names and phone numbers of witnesses			
20. How could this incident/accident have been prevented?			

21. Describe the specific actions to be taken to prevent a recurrence.

Immediate Supervisor (PRINT & SIGN)

Date

22. This report has been reviewed with me.

Employee's Signature

Date

Department/Division Safety Representative (PRINT & SIGN)

Date

Remarks by Division Head

Division Head (PRINT & SIGN)

Date

Remarks by Department Head

Department Head (PRINT & SIGN)

Date

THIS SECTION TO BE COMPLETED ONLY IF EMPLOYEE WAS TREATED BY A PHYSICIAN. Not to be completed for first aid or no treatment (incident) cases.

MEDICAL AUTHORIZATION

I hereby give authorization and permission to my physician(s) and/or hospital to release and disclose information relating to any medical diagnosis, medical records and medical treatment rendered to me to the Department of Civil Service, Health & Safety Division, County of Hawaii, 101 Pauahi Street, Hilo, HI 96720, telephone number 961-8344, and to their consultants and to their counsel.

Employee's Signature

Date

Distribution: 1. Copy to Health & Safety Division within 3 work days after incident/accident; if medical treatment rendered, a completed original WC-1 form must be attached.
2. Original retained by Department (for permanent retention).