

# Columbia County Report of Work Injury, Incidents and Accident Investigations

Supervisor to Complete, Sign and Deliver this original to the Human Resources Department within 24 hours of the event.

## Section A: To be completed by the Supervisor (Mandatory)

Employee's Name \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Time \_\_\_\_\_ Date Reported \_\_\_\_\_  
Time Workday Began \_\_\_\_\_ Normal Work Schedule \_\_\_\_\_ (Mon-Fri, Shift, etc.)  
Did employee work following day? \_\_\_\_\_ If not, was cause due to accident or shift? \_\_\_\_\_  
Returned to work \_\_\_\_\_ Location of incident \_\_\_\_\_  
Nature of Injury and part of body affected \*\*BE SPECIFIC \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Sheriff's Office or Police Department Case # \_\_\_\_\_ (If applicable. Attach a copy of the report to this form)  
Did this incident involve possible exposure to infectious agents or pathogens? \_\_\_\_\_

## Section B: Treatment (Mandatory)

\_\_\_\_ No apparent injury  
\_\_\_\_ Minor First Aid Only  
\_\_\_\_ Hospital or Emergency Care -----  
\_\_\_\_ Fatal Injury  
\_\_\_\_ Disabling Injury  
\_\_\_\_ Potential Permanent Injury

Work Hours Lost day of injury \_\_\_\_\_  
Total Lost time hours \_\_\_\_\_  
Transported by \_\_\_\_\_

Medical Treatment Offered? _____
Medical Treatment Accepted? _____
Medical Treatment Refused? _____
Employee's Signature _____

**Attach Medical Treatment Paperwork to this form!**

## Section C: Details of injury by Supervisor and/or Witnesses: (Be Specific on the facts leading to the Injury)

Use additional pages as necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all property involved** (include: Description & Serial #, Current location, Owner, and Extent of Damage).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Names and addresses of any others involved in this incident:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Mandatory) (Mandatory)

Original to Human Resources Department  
A separate form will be provided for Liability Claims from Risk Management

## **PART I - EMPLOYEE ELECTION STATEMENT**

Workers' compensation benefits entitle injured employees to compensation for lost wages due to a compensable work related injury. Georgia state law mandates that the employer or its insurer must pay an injured worker 66 2/3% of his/her average gross weekly wage, not to exceed the maximum of \$450.00, for the duration for his/her disability. State law designates a waiting period of seven calendar days of disability before income benefits are payable. However, should the injured employee remain disabled from employment for 21 calendar days, then the first seven days of disability (waiting period) would become compensable to the injured employee.

As an injured employee of Columbia County you have the option of using part or all of your accrued Personal Time Off (PTO) hours. However, any PTO hours used will not be reimbursed by the county's workers' compensation carrier/servicing agent. Should you elect not to use any PTO hours, you will be compensated for any period of disability according to statutory workers' compensation benefits.

I have read and understand the above. I elect to utilize the following options in lieu of statutory Work Comp benefits:

1. \_\_\_\_\_ Elect to utilize a portion of my accrued PTO hours in lieu of statutory workers' compensation benefits.
2. \_\_\_\_\_ Elect to utilize all of my accrued PTO hours in lieu of statutory workers' compensation benefits.
3. \_\_\_\_\_ Elect **not** to utilize my accrued PTO hours and elect to utilize statutory workers' compensation benefits.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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## **PART II - RELEASE TO RETURN TO WORK**

Returned to work on: \_\_\_\_\_  
                                    Month      Day      Year

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisor

**Attach Medical Release statement to this form. Forward to HR Department**



**Section F: Employee Statement**

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What caused this incident to occur? \_\_\_\_\_

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What preventive measures could have been taken to avoid this accident?

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\_\_\_\_\_  
Employee Signature (*Mandatory*)

\_\_\_\_\_  
Date