Workplace Accident and Injury Procedures

Please note that CSSU employees seeking non emergency medical care should now go to:

CHAMPLAIN MEDICAL URGENT CARE
150 Kennedy Drive
South Burlington, VT 05403
802-448-9370

Initial Accident and/or Injury:

1. **Employees** must report all injuries immediately to their supervisor, school nurse or building administrator. **If this is a medical emergency, please contact the Human Resources Department as soon as possible after seeking treatment for the injured employee at UVM Medical Center.**
2. **For non-medical emergencies, Supervisors, school nurses or building administrators will immediately seek medical treatment as appropriate. If no medical treatment is necessary continue to step three.**
   a. If this is a medical emergency, call 911 and have the employee transported to the emergency room at UVM Medical Center.
   b. If this is not a medical emergency, but the employee needs prompt medical attention go to:

      CHAMPLAIN MEDICAL URGENT CARE, 150 Kennedy Drive, South Burlington, VT 05403, 802-488-9370

      A Treatment Authorization Form may be required for the above facility. Supervisors, School Nurses and Building Administrators have the authority to sign off on these requests. If no such person is available locally, contact the Human Resources Department at Central Office at 383-1234 and send the employee; the company will bill us.
   c. If an accident occurs and minimal treatment or no treatment is required, move to step three.
3. Supervisors, school nurses or building administrators are responsible for ensuring completion of the **Workplace Accident Report** for all injuries they are aware of.
   a. Supervisors/building administrators should work with the injured employee to complete the **Workplace Accident Report** or complete it themselves with the help of any witnesses. **It is important to complete this immediately.**
   b. Fax all paperwork to the Human Resources (383-1242) as soon as possible or scan to rhedges@cssu.org and mmarshall@cssu.org no later than **24 hours** after the accident. Send over the forms even if some information is missing.
   c. If treatment is handled by the School Nurse or no treatment is required, the Supervisory Union still needs to report the claim so a Workplace Accident Report will have to be filled out.
4. **For injuries occurring within the Chittenden County area, the employee is required to be assessed by Champlain Medical Urgent Care unless otherwise approved in advanced by Human Resources**. For injuries out of the area, the employee is required to have the initial medical treatment at an appropriate treatment center approved by the Human Resources Director. Follow up for care management is thereafter required to be managed through Champlain Medical Urgent Care or as authorized by the Human Resources Director.
5. Employees who wish to have their care management coordinated by a medical provider other than that designated by the Supervisory Union may do so **after the initial visit to the Supervisory Union designated provider**. Such requests are to be formally made to the Human Resources Department and require completing appropriate documentation through the insurance carrier and the state.
6. **An initial visit to the employee's personal physician requires prior discussion with the Human Resources Department.**

Return To Work:

1. Injured employees are required to meet with the Supervisor or Building Administrator immediately after the initial medical attention has been provided to discuss return to work options.
2. If the employee is missing work due to the work related injury, the supervisor/building administrator must contact Human Resources to discuss how to properly report and pay these wages under Worker Comp.
3. All employees with return to work recommendations from the attending physician are required to explore all possible options for a safe and gradual return to work with the supervisor or building administrator.

Required Workers Compensation Forms:

a. Workers Compensation Procedures
b. Workplace Accident Report
c. Champlain Medical Urgent Care Treatment Authorization
d. Work Release/Return to Work – a physician note with restrictions or release to full work capacity would be provided by the treatment facility

CHITTENDEN SOUTH SUPERVISORY UNION *WORKPLACE ACCIDENT REPORT*

YOU ARE REQUIRED TO COMPLETE THIS FORM AND SEND TO HUMAN RESOURCES WITHIN 24 HOURS OF THE ACCIDENT/INJURY

Fax: 802-383-1242

Injured Employee's Legal Name:_____School:_____

Position:_____

On the day of injury:

Accident Date:_____Accident Time:_____

Employee started work time:_____Employee end work time:_____

Was the employee doing their regular job? ☐ YES ☐ NO

Who is the employee's direct supervisor?_____

DID EMPLOYEE SEEK MEDICAL TREATMENT? ☐ YES ☐ NO

WHO PROVIDED TREATMENT?

- ☐ CHAMPLAIN MEDICAL URGENT CARE
- ☐ EMERGENCY ROOM
- ☐ SCHOOL NURSE
- ☐ REFUSED TREATMENT
- ☐ OTHER (please describe):

DID EMPLOYEE LOSE ANY WORK TIME: ☐ YES ☐ NO ☐ Not Sure Yet

If YES, list specific LOST time the employee has been out of work due to this incident.

Sunday
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday

Who will follow up with the employee about their treatment: _____

Was the employee doing their regular job?☐ YES ☐ NO

1. Describe in full the events, which resulted in the injury or occupational illness.

2. What was the employee doing when injured? *(Be specific. If employee was using tools or equipment or handling material, name them and tell what the employee was doing with them.)*

3. Describe the injury or illness in detail and indicate the part of body affected *(E.g., Dermatitis of left hand, fractured right finger, etc.)*

4. What object or substance directly injured the employee? *(For example, the machine or object employee struck against or was struck by, vapors or fumes inhaled or swallowed, chemical which irritated the skin, or in cases of strains, hernias, etc., the object s/he was lifting, pulling, etc.)*

5. Describe any personal factors, mechanical, physical or environmental condition that contributed to accident:

6. Describe unsafe act or failure to act by employee (s) or others:

Who witnessed the accident? _____

Who was working with the injured?_____

Who else was involved in the accident?_____

Who trained the injured in this job?_____

What PERSONAL PROTECTIVE EQUIPMENT (PPE) was being used?

Did Personal Protective Equipment fail? YES ☐ NO ☐ N/A ☐

If employee was not wearing proper PPE, what PPE should have been used?

Specific comments and recommendations:

_____

Principal or Supervisor Signature Today's Date

_____

Employee's Signature Today's Date