Administrative Directive 3-31

SUBJECT: ON-THE-JOB INJURIES

1. PURPOSE

Establish standard procedures to be followed in the event of an on-the-job injury or occupational illness/disease.

2. SCOPE

Every employee injured while in the course and scope of employment for the City of Dallas must report the occurrence to his/her immediate supervisor. There are certain rights and privileges to which an injured employee is entitled under the workers' compensation laws. Reporting of the injury and the proper completion of the appropriate forms are necessary for the protection of employees and the City of Dallas. All forms must be timely filed.

3. DEFINITIONS

3.1 **First Aid** - Minor injury sustained that requires no medical treatment.

3.2 **Injury Review Board** – The responsibility of the board is to hear appeals requested the injured employee; review and evaluate the preventability of on-the-job injuries.

3.3 **Limited Duty** - Days of restricted work activity during which the employee is assigned to another job on a temporary basis or the employee works his/her assigned job but is unable to perform all duties normally connected with it.

3.4 **Lost Time** - Injury sustained and medical treatment rendered with one or more working days lost.

3.5 **Medical Only** - Injury sustained and medical treatment rendered but time lost is less than one full workday.

3.6 **Near-Miss** – A work-related event that occurred or could have occurred but did not result in injury, ill health or fatality.

3.7 **Preventable Accident** – Accident in which the employee 1) failed to take reasonable actions which could have avoided or prevented the accident and/or 2) violated a City or departmental rule, policy, or procedure which contributed to the accident.

3.8 **Safety Officer** – The Office of Risk Management designated employee or department designated employee who provides safety consultation services to the department.

3.9 **Third Party Administrator** - Private firm under contract, by the City, to administer workers' compensation claims.

3.10 **Texas Department of Insurance (TDI)** - State agency empowered to administer provisions of the workers' compensation laws, through the Division of Workers' Compensation.

3.11 **Texas Workers' Compensation Health Care Certified Network** – A program that is certified by the State of Texas to provide healthcare services for injured workers.

3.12 **Network Administrator** – Private firm under contract by the City, to administer the Certified Network.

3.13. **Service Area –** Any county where the network operates with physicians and other healthcare providers to care for injured employees.

4. FORMS

The following must be prepared and submitted to the departmental workers' compensation coordinator for on-the-job injuries:

4.1 ***Supervisor's Injury Investigation Report*** **[Exhibit A]** – Completed and submitted by the injured employee's supervisor within 24 hours, if possible, after knowledge/notification that an on-the-job injury or occupational illness/disease has occurred. This form has a section for the DWC1 information.

4.2 ***Order for Medical Treatment*** **[Exhibit B]** – Prepared when an employee has returned to work and requires medical treatment.

4.2.1 Should be completed by the medical provider and returned to departmental workers' compensation coordinator on the day of the office visit or the next business day***;***

4.2.2 Should not be used for claims the third party administrator has denied.

4.3 **Supplemental** ***Report of Injury (DWC6)*** – Submitted by the departmental workers' compensation coordinator to the third party administrator and injured worker. Failure to comply with requirements, without good cause, is a violation of the law and may subject the city to a penalty for each violation. Click this link to access form http://www.tdi.state.tx.us/forms/dwc/dwc6.pdf.

4.3.1 For injuries that require a DWC1 to be filed, a DWC6 must be filed within **three** days after the injured worker returns to work and when the injured worker experiences additional day(s) of lost time as a result of the injury after returning to work.

4.3.2 The DWC6 must be filed within **ten** days after the end of each pay period in which the employee has a change in earnings as a result of the injury or when the employee resigns or is terminated.

5. PROCEDURES

5.1 When an on-the-job injury occurs, the employee must report the event within twenty-four (24) hours to his/her immediate supervisor. If it appears the injury is serious or might result in death, the supervisor should contact Risk Management immediately. Risk Management may be contacted at (214) 671-9458 between the hours of 8:15 a.m. to 5:30 p.m., Monday through Friday or after hours by sending an email to: *hrsafety@dallascityhall.com*.

5.2 Within 24 hours of knowledge of an injury, the supervisor must complete the ***Supervisor's Injury Investigation Report*** (Exhibit A) and submit it along with the preventability recommendation to the departmental workers' compensation coordinator and safety officer. The supervisor shall notify the employee, in writing, of the recommendation.

5.3 The departmental workers' compensation coordinator shall enter all claim information into the workers' compensation system within one business day of receipt.

5.4 Departments will provide an ***Order for Medical Treatment*** *(OMT)* form to an employee who sustains a bona-fide on-the-job injury, which requires medical treatment and is not questionable as a result of course and scope of employment. The injured employee must return the fully completed OMT form to the departmental workers' compensation representative on the day of the visit to medical provider or the next business day.

5.5 Within 10 working days of receiving the supervisor's written recommendation, the safety officer will review the information provided by the supervisor, conduct any needed follow-up investigation and either concur or disagree with the supervisor's recommendation.

5.6 To the extent that the safety officer disagrees with the supervisor's recommendation, the safety officer's ruling shall take precedence. The safety officer shall notify the supervisor in writing of the preventability ruling. The supervisor shall notify the employee, in writing, within 3 business days of the safety officer's ruling, appeals rights and appeals procedures.

5.7 An injured employee has the right to appeal a preventable injury ruling to the Injury Review Board by submitting a request, in writing, to Director of the Office of Risk Management, City Hall, Room 6AS, within 10 business days after having received written notification of the safety officer ruling.

5.8 The Injury Review Board will hear appeals from employees who do not agree with the safety officer's ruling. Within ten (10) working days from the date of receiving notification of the safety officer's ruling, the employee must submit the request for an appeal. The appeal will be scheduled for the next available hearing date from receipt of the request. Decisions of the Injury Review Board shall be final; however, the City Manager may remand decisions of the Injury Review Board.

5.9 Departments are not allowed to assign points for any injuries whether preventable or non-preventable.

5.10 It is the responsibility of every employee, supervisor and manager to report fraudulent claims or malingering. Any questions regarding this A.D. should be directed to the Office of Risk Management at (214) 671-9458.

6. RETALIATION PROHIBITED

The City prohibits any form of retaliation against an employee for filing a bona fide report of an on-the-job injury. Any employee, including managers and supervisors, retaliating against an employee who reports an on-the-job injury in good faith will be subject to corrective action, up to an including discharge from employment. Employees who believe they are suffering retaliation as a result of making a report under this Directive are required to make a prompt report to his or her immediate supervisor or to the Department of Human Resources.

7. PRIOR ACTION

7.1 Latest Revision Date: September 13, 2012
Effective Date of Revised AD: September 13, 2012

8. ISSUING DEPARTMENT: Office of Risk Management

Exhibit A

CITY OF DALLAS SUPERVISOR'S INJURY INVESTIGATION REPORT

INSTRUCTIONS: 1. ALL on-the-job injuries or illnesses must be investigated and reported to Risk Management within 24 hours. 2. Fill out Supervisor's Injury Investigation Report fully and forward to your Department Worker's Compensation Representative. 3. Refer to Administrative Directive 3-31, On-Job Injuries. When following investigation procedure below keep two basic points in mind:

- That most accidents involve both unsafe conditions and unsafe acts, and
- That the purpose of accident investigation is prevention of future accidents and not fixing of blame.

INVESTIGATION: Go to the scene of the accident promptly. 2. Talk with the injured person, if possible. Talk with witnesses. Stress getting the facts, not placing the responsibility or blame. 3. Listen for clues in the conversations around you. Unsolicited comments often have merit. 4. Encourage people to give their ideas for preventing the accident. 5. Study possible causes -- both unsafe conditions and unsafe practices. 6. Confer with interested persons about possible solutions. The problem may have been solved by someone else. 7. Take photographs when necessary. 8. Follow up to make sure conditions are corrected. If they cannot be corrected immediately, report this to all concerned.

Please (X) the item most relative to the injury in EACH of the following:

1. EMPLOYEE STATUS
☐ 01 Full-time Permanent
☐ 04 Retired
☐ 06 Temporary
☐ 08 Volunteer
☐ 09 Prisoner Work Release
☐ 10 Part-time/Permanent
☐ 00 Summer Youth

2. INJURY TYPE
☐ 01 Death Claim
☐ 05 Lost time-one or more
☐ 06 NLT-Medical Only
☐ 07 First-Aid -- Info Only

3. PART OF BODY

HEAD
☐ 10 Multiple Head Injury Area
☐ 11 Skull
☐ 12 Brain
☐ 13 Ear(s)
☐ 14 Eye(s)
☐ 15 Nose
☐ 16 Teeth
☐ 17 Mouth
☐ 18 Other Facial Soft Tissue
☐ 19 Facial Bones

NECK
☐ 20 Multiple Neck Injury
☐ 21 Vertebrae
☐ 22 Disc
☐ 23 Spinal Cord
☐ 24 Larynx
☐ 25 Soft Tissue
☐ 26 Trachea

UPPER EXTREMITIES
☐ 30 Multiple Upper Extremities
☐ 31 Upper Arm
☐ 32 Elbow
☐ 33 Lower Arm
☐ 34 Wrist
☐ 35 Hand
☐ 36 Finger(s)
☐ 37 Thumb

TRUNK
☐ 40 Multiple Trunk
☐ 41 Upper Back Area

TRUNK (Cont.)
☐ 42 Low Back
☐ 43 Disc
☐ 44 Chest (Inc: Ribs, Sternum and Soft Tissue)
☐ 45 Sacrum and Coccyx
☐ 46 Pelvis
☐ 47 Spinal Cord
☐ 48 Internal Organs
☐ 49 Heart

LOWER EXTREMITIES
☐ 50 Multiple Lower Extremities
☐ 51 Hip
☐ 52 Thigh
☐ 53 Knee
☐ 54 Lower Leg
☐ 55 Ankle
☐ 56 Foot
☐ 57 Toe(s)

MULTIPLE BODY PARTS
☐ 90 Multiple Body Parts

4. SIDE OF BODY
☐ 01 Right
☐ 02 Left
☐ 03 Front
☐ 04 Back
☐ 05 Multiple Sides

5. KIND OF ACCIDENT

BURN OR SCALD -- HEAT 0R COLD EXPOSURE
☐ 01 Acid Chemicals
☐ 02 Contact w/Hot Object
☐ 03 Temperature Extremes
☐ 04 Fire or Flame
☐ 05 Steam or Hot Fluids
☐ 07 Welding Operations
☐ 08 Miscellaneous

KIND OF ACCIDENT (Cont.)

CAUGHT IN OR BETWEEN
☐ 10 Machine or Machinery
☐ 12 Object Handled
☐ 13 Miscellaneous

CUT, PUNCTURE, SCRAPE, INJURED BY
☐ 15 Broken Glass
☐ 16 Hand Tool, Utensil; Not Powered
☐ 18 Powered Hand Tool, Appliance
☐ 19 Miscellaneous

FALL OR SLIP INJURY
☐ 25 From Different Level
☐ 26 From Ladder or Scaffolding
☐ 27 From Liquid or Grease Spills
☐ 29 On Same Level
☐ 30 Slipped, Did Not Fall
☐ 31 Miscellaneous

MOTOR VEHICLE
☐ 45 Collision with Another Vehicle
☐ 46 Collision with a Fixed Object
☐ 47 Crash of Airplane
☐ 48 Vehicle Upset
☐ 50 Miscellaneous

STRAIN OR INJURY BY
☐ 54 Jumping
☐ 55 Holding or Carrying
☐ 56 Lifting
☐ 57 Pushing or Pulling
☐ 58 Reaching
☐ 59 Using Tool or Machine
☐ 60 Miscellaneous

STRIKING AGAINST/STEPPING ON
☐ 65 Moving Parts of Machine
☐ 66 Object Being Lifted or Handled
☐ 67 Sanding, Scraping, Cleaning Operations
☐ 68 Stationary Object
☐ 69 Stepping on Sharp Object
☐ 70 Miscellaneous

STRUCK OR INJURED BY
☐ 75 Falling or Flying
☐ 76 Hand Tool or Machine in Use
☐ 77 Motor Vehicle
☐ 78 Moving Parts of Machine
☐ 79 Object Being Lifted or Handled
☐ 80 Object Handled by Others
☐ 81 Miscellaneous

MISCELLANEOUS CAUSES
☐ 84 Contact with Electric Current
☐ 85 Animal or Insect
☐ 86 Exposure or Flare Back
☐ 87 Foreign Body in Eye
☐ 89 Robbery or Criminal Assault
☐ 98 Cumulative (All Other)
☐ 99 Other

6. AGENCY OF ACCIDENT
☐ 41 Air Pressure
☐ 42 Chemicals: Compound/Gas/Liquid
☐ 43 Containers: Boxes/Barrels/Skid
☐ 44 Clothing: Apparel/Shoes/Jewelry
☐ 45 Conveyers: Power or Gravity
☐ 46 Mineral Items: Dirt/Stone/Dust
☐ 47 Power Apparatus: Tools/Motors
☐ 48 Excavations: Trenches/Tunnels
☐ 49 Fixtures/Furniture/Furnishings
☐ 50 Glassware: Bottles/Sheet Glass
☐ 51 Glass Fibers, Cloth, Paper
☐ 52 Hand Tools (Non-powered)
☐ 53 Hoisting Apparatus: Cranes, Etc.
☐ 54 Heating Equipment: Furnaces/Stoves
☐ 55 Infections/Disease/Agents

AGENCY OF ACCIDENT (Cont.)
☐ 57 Metal/Wood/Plastic Proc. Equipment
☐ 58 Mech Power Trans: Belts/Gears
☐ 59 Sharp Objects: Needles/Knives
☐ 60 Pressure/Storage Tanks/Cylinder
☐ 61 Radiation: X-ray/Welding, Etc.
☐ 62 Metal Items: Plates/Rods/Scrap
☐ 63 Vehicles: Non-Powered/Powered
☐ 64 Wood Items: Logs/Lumber, Etc.
☐ 65 Work Surfaces: Indoor/Outdoor, including on ice
☐ 66 Miscellaneous Agents of Injury
☐ 67 Person other than the Injured
☐ 68 Insufficient Data to Determine
☐ 69 Recreational Activity/Equipment
☐ 70 Environmental Noise/Temperature
☐ 71 Food
☐ 72 Animals and Insects
☐ 73 Building Structures: Doors/Etc.
☐ 99 Unknown/Other

7. PERSONAL PROTECTIVE EQUIPMENT
☐ 01 Not Applicable
☐ 02 Not Available
☐ 03 Not Used
☐ 04 Ineffective
☐ 05 Defective

8. MULTIPLE EMPLOYEES INJURED THIS OCCURRENCE
☐ 01 2 Employees
☐ 02 3 Employees
☐ 03 4 Employees
☐ 04 5 or more Employees

9. TIME IN PRESENT JOB
☐ 00 In Training
☐ 01 Less than Six Months
☐ 02 6 Months To 1 Year
☐ 03 1-3 Years
☐ 04 3-5 Years
☐ 05 5-10 Years
☐ 06 10-20 Years
☐ 07 Over 20 Years

10. CITY EQUIPMENT
☐ City Equipment-on road
☐ City Equipment-off road
☐ Police take-Home vehicle
☐ Employee personal vehicle

11. TYPE OF REFUSE
☐ Dumpster
☐ Plastic Bag
☐ Cardboard Box
☐ Igloo
☐ Brush
☐ More than one Container
☐ Other

12. EXPOSURE TO COMMUNICABLE DISEASE
☐ 01 Hepatitis
☐ 02 Tuberculosis
☐ 03 HIV/AIDS
☐ 04 Rabies
☐ 05 Meningitis
☐ 06 Other

13. AGGRESSIVE ACTIONS
☐ 01 Animal
☐ 02 Citizen
☐ Prisoner
☐ Other Employee

☐ 01 Animal
☐ 02 Insect
☐ 03 Human

15. PUNCTURES/CUTS
☐ 01 Nail/Screw/Wire
☐ 02 Stick/Brush
☐ 03 Needle/Syringe
☐ 04 Glass
☐ 05 Metal Object/Knife

16. LAST TETANUS SHOT

one year

☐ 03 3-5 Years
☐ 04 More than 5 Years

17. WEAPONS
☐ 01 Gun
☐ 02 Knife
☐ 03 Club

Object
☐ 06 Needle/Syringe

Exhibit A (continued)

18. NATURE OF INJURY
SPECIFIC INJURY
- ☐ 02 Amputation
- ☐ 03 Angina Pectoris (Condition associated with the heart)
- ☐ 04 Burn
- ☐ 07 Concussion
- ☐ 10 Contusion
- ☐ 13 Crushing
- ☐ 16 Dislocation
- ☐ 19 Electric Shock
- ☐ 22 Enucleation (To remove, Ex: Tumor, Eye, etc.)
- ☐ 25 Foreign Body
- ☐ 28 Fracture
- ☐ 30 Freezing
- ☐ 31 Hearing Loss (Traumatic Only)
- ☐ 32 Heat Prostration/Heat Stress
- ☐ 34 Hernia
- ☐ 36 Infection
- ☐ 37 Inflammation
- ☐ 40 Laceration
- ☐ 41 Myocardial Infraction
- ☐ (Heart Attack)
- ☐ 43 Puncture, including gunshots, bites
- ☐ 46 Rupture
- ☐ 47 Severance
- ☐ 49 Sprain
- ☐ 52 Strain
- ☐ 54 Asphyxiation
- ☐ 55 Vascular Loss
- ☐ 58 Vision Loss
- ☐ 59 All Other

NATURE OF INJURY (Cont.)
OCCUPATIONAL DISEASE OR CUMULATIVE INJURY
- ☐ 60 Dust Disease NOC (All other Pneumoconiosis)
- ☐ 61 Asbestosis
- ☐ 62 Black Lung
- ☐ 63 Byssinosis
- ☐ 64 Silicosis
- ☐ 65 Respiratory Disorders (Gases, Fumes, Chemicals, etc.)
- ☐ 66 Poisoning-Chemical
- ☐ 67 Poisoning-Metal
- ☐ 68 Dermatitis
- ☐ 69 Mental Disorder
- ☐ 70 Radiation
- ☐ 71 All Other Occupational Disease
- ☐ 72 Loss of Hearing
- ☐ 73 Contagious Disease
- ☐ 74 Cancer
- ☐ 75 AIDS
- ☐ 76 VDT-Related Disease
- ☐ 77 Mental Stress
- ☐ 78 Carpal Tunnel Syndrome
- ☐ 80 All Other Cumulative Injuries

19. CAUSE OF INJURY
- ☐ 1A Aggressive Act of Another
- ☐ 1B Athletic Injury
- ☐ 1C Animal/Insect
- ☐ 1D Alcohol/Drug Influence
- ☐ 1E Driving Error
- ☐ 1F Inattention

CAUSE OF INJURY (Cont.)
- ☐ 1G Taking Shortcut
- ☐ 1H Working at Unsafe Speed
- ☐ 1J Not Following Rule/Instructions
- ☐ 1K Poor Teamwork
- ☐ 1L Using Wrong Tool
- ☐ 1M Using Tool/Machine Improperly
- ☐ 1N Not Wearing Protective Equipment
- ☐ 1P Improper Protective Equipment
- ☐ 1Q Unsafe Position/Posture
- ☐ 2A Defect in Material/Object
- ☐ 2B Hazardous Object Handled
- ☐ 2C Weight/Shape of Object
- ☐ 2D Foreign Body in Eye/ No Specific Cause
- ☐ 2E Terrain Hazard
- ☐ 2F Hidden/Unseen Hazard
- ☐ 2G Unguarded/Defective Machine
- ☐ 2H Apparel/Clothing Hazard
- ☐ 2J Excessive Noise
- ☐ 2K Poor Illumination
- ☐ 2L Excessive Dust/Gas/Smoke
- ☐ 2M Inadequate Ventilation
- ☐ 2N Other Environmental Condition
- ☐ 2P Poor Housekeeping
- ☐ 2Q Slippery/Defective Surface
- ☐ 3A No Obvious Cause
- ☐ 3B Recurrence of Old Injury
- ☐ 3D VDT-Related
- ☐ 3C Other Injury________________________

20. Name (Last,First,M.I.)	21. Employee #	22. Date of Injury (m-d-y):	23. Time of Injury : am ☐ pm ☐	24. Date Lost Time Began (m-d-y)
25. Social Security Number 26. Phone # (AC)	27. Sex F ☐ M ☐	28. Org #	29. Department	30. Claim #
31. Does the Employee Speak English? If No, Specify Language Yes ☐ No ☐	32. Date of Birth (m-d-y)	33. How and Why Injury/Illness Occurred		
34. Race ☐ White ☐ Black ☐ Asian 35. Ethnicity ☐ Hispanic ☐ Native American ☐ Other				
36. Mailing Address Street or P.O. Box		37. Was employee doing his/her regular job? Yes ☐ No ☐		38. Physical Location Code
39. City State Zip Code County		40. Address Where Injury or Exposure Occurred (if different than physical location code) Name of business if incident occurred on a business site		
41. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐		42. Street or P.O. Box County		
43. Number of Dependent Children 44. Spouse's Name		45. City State Zip Code 46. Cause of Injury (fall, tool, machine, etc.)		
47. Doctor's Name (for ER or Clinic)		48. List Witnesses and Phone Numbers		
49. Doctor's Mailing Address (Street or P.O. Box)		50. Return to Work date/or expected (m-d-y)	51. Did employee die? Yes ☐ No ☐	52. Date Reported (m-d-y)
53. Name the safety appliance or regulation provided Was it in use at the time? Yes ☐ No ☐				
54. Was accident caused by employee's failure to use or observe safety appliance or regulation? Yes ☐ No ☐				
55. Date of Hire (m-d-y) 56. Was employee hired or recruited in Texas? Yes ☐ No ☐		57. Length of Service in Current Position Months _______ Years _____	58. Length of Service in Occupation Months __________ Years _________	
59. Employee Payroll Classification Code		60. Occupation of Injured Worker	61. Termination Date:	
62. Rate of Pay at this Job $_________________Hour $______________ Weekly	63. Full Work Week is: ___ Hours ____ Days	64. Last Paycheck was: $_____________ for __________ Hours or _______ Days		65. Specific Standard Industrial Classification (SIC) Code
66. Supervisor's Name		67. Date Form Completed		
68. Supervisor's Signature		69. Supervisor's Employee #		
70. Supervisor's Title/Rank		71. Supervisor's Work Phone		72. Adjuster Investigation Required ☐ Yes ☐ No ☐

Order for Medical Treatment
City of Dallas

Doctor's Findings and Disposition

Patient ______________________________
(Name of Employee)

has been treated for ______________________________
(Injury of Illness)

____

☐ Occupational ☐ Non-Occupational

LIGHT DUTY IS AVAILABLE

And is

☐ Able to resume regular duties.

Date ______________________________

☐ Able to resume light duty. (Restrictions in remarks)

Date ______________________________

☐ Unable to return to work at this time.
May return to work ____________________ (If known)
(Date)

☐ Return for treatment on ____________________
(Date)

☐ Hospitalized ______________________________
(Name of Hospital)

By ______________________________ M.D.

Date ______________________________

Arrival Time ______________________________

Departure ______________________________

Remarks ______________________________

____

____

____

TO: Dr. ______________________________

Address: ______________________________

FROM: Dept. ______________________________

Div. ______________________________

Address: ______________________________

PLEASE RENDER TREATMENT TO:

Employee: ______________________________

Address: ______________________________

Occupation: ______________________________

Date of Injury ____________________ Hour ____________

Nature of Injury ______________________________

____

How Occurred ______________________________

____

____

____

(continue on reverse side)

Issued by ____________________ Title ____________________

Date of Order ______________ Time ______________

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