

S&E Report

Employee Incident Report

(Complete/email within 24 hours to rmclaims@horrycounty.org)

1. Immediately report incident or damage to your supervisor. Send completed report to Risk Management within 24 hours of incident.

A. TYPE OF INCIDENT - CIRCLE ALL THAT APPLY

- 1000 - Motor Vehicle Incident
 1002 - Personal Injury/Illness
 1003B - Non-County Employee Injury
 1001 - County Vehicle Damages
 1003A - Non-County Property Damage
 1006 - Damage to other County Property

B. EMPLOYEE INFORMATION

Print Department Name: _____

Last Name		First Name		MI	Age
ID. #	Position/Title		Supervisor's Name		

EMPLOYEE GENDER

- 1007 - Male
 1009 - Full- Time
 100 Female
 1010 - Part- Time

EMPLOYEE STATUS

- 1011- Temporary (FT - PT)
 1013- Non-County Employee
 1012- Volunteer

Incident Date	Time of Incident	<input type="checkbox"/> AM or <input type="checkbox"/> PM	Incident Location
Vehicle Year / Model or Other Property Description			Seat belts used <input type="checkbox"/> YES <input type="checkbox"/> NO
VIN or Serial #		Asset #	
Describe Property Damages			Employee cited <input type="checkbox"/> YES <input type="checkbox"/> NO
Passengers Name and Address			
Personal Injury <input type="checkbox"/> YES <input type="checkbox"/> NO Describe:			

NUMBER OF HOURS INTO SHIFT

- 1024- 0-1 Hour
 1025- 2-3 Hours
 1026- 4-5 Hour
 1027- 6-7 Hours
 1028- 8-9 Hours
 1029- 10 Hours or more

DESCRIPTION OF INCIDENT IN THE EMPLOYEE'S WORDS (Print or Type and Attach Additional Statements)

C. Other Driver, Claimant, Other Party, or Other Owner Information: Attach Statements of Non-County Employees

Name, Address, and Telephone Number

Insurance Company / Policy #:

Personal Injury YES NO Describe:

Vehicle Year / Model or Other Property Description

VIN or Serial #

Describe Property Damages

Claimant statement attached YES NO

Employee Signature	Today's Date	Date Reported to Supervisor
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S&E REPORT

SUPERVISOR'S INVESTIGATION REPORT

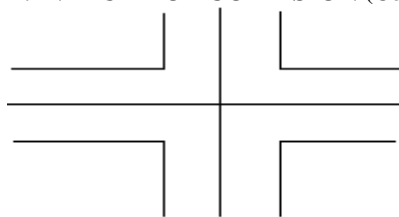
(Complete within 24 hours)

D. **WITNESSES:** List Names, Addresses, and Phone Numbers. Attach Witness Statements. Get them before they forget.

E. INJURY/ILLNESS/EXPOSURE TREATMENT/OUTCOME

- 1136 - First Aid Treatment
 1138 - Medical Treatment Provided by:
 1139 - No Treatment Required
 1137- Lost Workdays
 1140 - Restriction of Work Activities
 Yes No

F. NATURE OF COLLISION (Complete/modify diagram/provide pictures)



- | | | |
|--|--|---|
| Type | Road Surface | Weather Conditions |
| <input type="checkbox"/> 1141 - Single Vehicle | <input type="checkbox"/> 1147 - Wet | <input type="checkbox"/> 1152 - Clear |
| <input type="checkbox"/> 1142 - Multi-Vehicles | <input type="checkbox"/> 1148 - Dry | <input type="checkbox"/> 1153 - Cloudy |
| <input type="checkbox"/> 1143 - Parked Vehicle | <input type="checkbox"/> 1149 - Snow or Ice | <input type="checkbox"/> 1154 - Foggy |
| <input type="checkbox"/> 1144 - Heavy Equip. | <input type="checkbox"/> 1150 - Mud or Other | <input type="checkbox"/> 1155 - Raining |
| <input type="checkbox"/> 1145 - Backing | <input type="checkbox"/> 1151 - Unknown | <input type="checkbox"/> 1156 - Snowing |
| <input type="checkbox"/> 1146 - Other: _____ | | <input type="checkbox"/> 1157 - Other/Unknown |

I N V E S T I G A T I O N	Check All Boxes That Apply: DIRECT CAUSES		BASIC CAUSES
	<i>UNSAFE ACTS OF INDIVIDUAL</i>	<i>UNSAFE CONDITIONS OF WORK AREA OR EQUIP.</i>	<i>AREAS FOR DEPARTMENT/SUPERVISOR/INDIVIDUAL IMPROVEMENTS because of</i>
	<input type="checkbox"/> Failure to follow procedures	<input type="checkbox"/> Inadequate guards or protection	<input type="checkbox"/> Inadequate hiring/placement practices
	<input type="checkbox"/> Failure to use safe practice or personal protective equipment	<input type="checkbox"/> Defective tools, equipment, machine or vehicle	<input type="checkbox"/> Procedures not enforced or inadequate training/procedures
	<input type="checkbox"/> Physical or mental limitations	<input type="checkbox"/> Congested work area/roadways	<input type="checkbox"/> Improper layout or design of work area
	<input type="checkbox"/> Improper Lifting, lowering or carrying technique	<input type="checkbox"/> Unsafe floors, ramps, stairways, platforms	<input type="checkbox"/> Inadequate job planning or worksite hazard analysis by supervisor
	<input type="checkbox"/> Removed safety devices	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Lack of preventive maintenance
	<input type="checkbox"/> Operating vehicle, equipment or machine at unsafe speed or unsafe manner	<input type="checkbox"/> Hazardous atmosphere: gases, dust, fumes, vapors or inadequate ventilation	<input type="checkbox"/> Unsafe design of equipment or work area
	<input type="checkbox"/> Unaware of hazards or operating without authority	<input type="checkbox"/> Inadequate warning system	<input type="checkbox"/> Vehicle or equipment inspection process not adequate or not enforced
	<input type="checkbox"/> Unsafe act of non-employee	<input type="checkbox"/> Limited visibility or adverse weather	<input type="checkbox"/> Employee insubordination or dishonesty or substance abuse
<input type="checkbox"/> Horseplay	<input type="checkbox"/> Poor road conditions	<input type="checkbox"/> Pre-existing physical condition	
<input type="checkbox"/> Other-EXPLAIN:	<input type="checkbox"/> Other-EXPLAIN:	<input type="checkbox"/> Other-EXPLAIN:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Using careless, hazard of job, and N/A are not acceptable investigation terms. Attach additional statements and reports.

A C T I O N S	Direct Causes: WHAT ACTIONS WERE TAKEN TO REMOVE DIRECT CAUSES OR WHAT HAPPENED IN DEPARTMENT?	Who Completed this Action?	DATE COMPLETED
	Basic Causes: WHAT ACTIONS WERE TAKEN TO REMOVE BASIC CAUSES? LIST ANY SAFETY PRACTICES THAT CAN BE PERFORMED TO HELP PREVENT REOCCURRENCE IN DEPARTMENT.	Who Completed IT & WHO Affected in Department By these Corrective Actions	DATE COMPLETED

Print Supervisor/Investigator Name	Supervisor Signature	Investigation Date	Date Notified of Accident
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Department Accident Audit Checklist: (Complete within 48 hours or request 5 days extension. Email to Risk Management at rmclaims@horrycounty.org.)

Check Basic Procedures & Risk Management Standards Completed

- Y N Sent accident report to Risk Management within 24 hours.
- Y N Completed investigation
- Y N Completed corrective actions.
- Y N Sent copy of any employee medical restrictions to Risk Management and used light duty program to comply with restrictions from doctor if applicable.
- Y N Used designated doctor – Doctors Care.
- Y N N/A Completed post-vehicle accident drug screen within 24 hours. Date: _____
- Y N N/A Completed Driver alcohol screen within 2 hours. Date: _____
- Y N N/A Took vehicle to Fleet Service or Fleet designated Body Shop within 24 hours or (next business day). Date completed _____

Supervisor Self Compliance Audit and Risk Management Checklist

1. Accident Date:	2. Accident Time:	<input type="checkbox"/> AM <input type="checkbox"/> PM
3. Employee and/or Claimant Name:		
4. Date Notice of Accident Received by Supervisor or Supervisor-in-charge:		Within 24 Hrs? <input type="checkbox"/> Y <input type="checkbox"/> N
5. Investigation of All Causes Determined? <input type="checkbox"/> Y <input type="checkbox"/> N Describe causes/what happened.		
6. Confirm actual actions/corrections taken. What was done? What is the Status? Who benefited from the changes and how are similar accidents in your department prevented?		7. Dates Completed?
8. Designated Physician – Doctors Care Used? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not used, why not?
9. Light Duty Used: <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Describe light duty assignment.
11. Audit requires Department Head, Asst. County Administrator, or County Administrator Signature:		12. Date Reviewed:

Attention Supervisor: Please complete this form for a drug screen/alcohol testing

POST VEHICLE ACCIDENT - AUTHORIZATION FORM

Employee Name:

Date of Accident:

Employer: Horry County Government Dept:

Is a drug screen required? Yes No If Yes, What type?

Is alcohol screening required? (If CDL) Yes No

Has employer filled out First Report of Injury? Yes No

This certifies that the above information is correct. I authorize the medical provider to provide the above testing for the employee as "marked"

This section to be completed by supervisor

Did supervisor accompany employee to the medical facility? YES No

(Failure to check will indicate a "no" response)

Supervisor's Signature _____

Please Print Name:

Position/Title:

Date: