

North Carolina Department of Natural and Cultural Resources
Division of Parks and Recreation

SAFETY POLICY
PERSONAL INJURY AND
WORKERS' COMPENSATION PROCEDURE



December 14, 2018

1.0 INTRODUCTION

It is the policy of the Division of Parks and Recreation (DPR) that all accidents or incidents that result in personal injury shall be properly reported and investigated.

2.0 PURPOSE

This program has been established to:

- Provide a systematic process to ensure that accidents/incidents are properly reported.
- Ensure proper documentation is provided in a timely manner.
- Ensure regulatory compliance and reduce future accidents/incidents.

3.0 SCOPE

This procedure applies to the Division of Parks and Recreation. This program applies to all permanent, probationary, temporary, trainee, and seasonal employees, volunteers, and community service workers who are injured during the performance of their duties. This policy applies to the reporting and investigating of all DPR work-related injuries.

*Note: This procedure does not apply to reporting of damaged DPR-owned property/equipment, damage to non-DPR property/equipment, or personal injury to anyone other than permanent, probationary, temporary, trainee, and seasonal employees, volunteers, and community service workers. A PR-63 North Carolina State Parks Case Incident/Investigation Report and SBI-78 State Property Incident Report will be completed in these cases.

4.0 DEFINITIONS

Incident - An accident which resulted in personal injury, damage to property, or loss of production.

Near Miss - A hazardous condition or event that could have resulted in an actual incident involving injury or property loss if the timing or location shifted slightly.

Workers' Compensation Administrator (WCA) - The employee who has been assigned Workers' Compensation responsibilities for DPR.

5.0 RESPONSIBILITIES

DPR Administration and Section Chiefs

- a) Ensure that all accidents/incidents are properly reported and investigated in accordance with the operating procedures.

- b) Ensure that all corrective actions are promptly and completely carried out.
- c) Designate employees responsible for the implementation of this program.
- d) Actively support this program to demonstrate overall safety culture development.
- e) Ensure Adequate funding is available to support all mandatory aspects of this Program.

DPR Safety Consultant

- a) At the direction of the Chief of Operations, will either conduct or delegate the investigation of all incidents and near misses.
- b) Notify the DPR Chief of Operations and the DNCR Safety Director if further assistance is needed in the investigation process.
- c) Monitor the results of the program and determine additional areas of focus that are needed.

Supervisors

- a) Acknowledge responsibility and accountability for the health and safety of DPR employees.
- b) Use the **Supervisor Incident Investigation Report** to document the details of an incident or near miss.
- c) Submit the appropriate reports and forms to the Workers' Comp Administrator.
- d) Ensure that all subordinate employees have received appropriate Safety and Health training.
- e) Implement corrective actions and ensure they are completed through active follow-up in a timely manner.

Employees

- a) Obtain appropriate first aid or medical treatment immediately if an incident occurs involving personal injury.
- b) Immediately report any incident or near miss to supervisor.
- c) Complete the **Employee Incident Report** and give it to the supervisor immediately, if possible, or no later than 24 hours after the incident.
- d) Actively participate in the investigation process to help determine hazards and appropriate corrective actions.

Workers' Compensation Administrator (WCA)

- a) Liaison to ensure Office of State Human Resources requirements are being met.
- b) Review workers' compensation submissions for completion and accuracy.
- c) Submit reports and statements to third party administrator within one day of receiving workers' compensation submissions.
- d) Point of contact for Workers' Compensation third party administrator.

6.0 POLICY/PROCEDURE

Accident/Injury Response

Immediately upon notification of any injury to an employee while performing job duties, the manager/supervisor of the injured/involved employee will:

- a) Ensure all injured employees receive necessary medical attention.
- b) Ensure that no other employees can be injured from the condition and that damage is not continuing.
- c) Investigate the accident and/or injury.

*Note – Serious injuries including fatalities, amputation, loss of one or both eyes and hospitalization of personnel will be reported in accordance with DPR staff directive 16-03. (Appendix B).

Investigation

All accidents involving personal injury to applicable staff will be investigated in accordance with [OSHR's Incident Investigation and Reporting Program](#):

- a) The investigation should determine the following:
- b) The cause(s) of the accident or injury.
- c) The relevant events leading up to the accident/injury.
- d) Unsafe conditions which contributed to the accident/injury.
- e) Actions of the employee which contributed to the accident/injury.
- f) Witnesses to the accident/injury.
- g) Recommendations to prevent a similar accident/injury from recurring in the future.

Documentation

Supervisors can obtain, complete, and submit forms within the DPR database under the [Workers' Comp/Accidents](#) link.

Workers' Compensation Reporting Forms:

- a) **Employee Incident Report** – This form is to be completed by the employee and should be an accurate account of the accident/incident.
- b) **Supervisor Incident Investigation Report** – This form is to be completed by the investigating supervisor who will describe the accident/incident and determine a root cause.
- c) **Witness Statement Form** – Witnesses to accidents/incidents will complete this form describing the event in as much detail as possible. (if applicable)
- d) **Injury Data Collection Form** – This form is completed as soon as reasonably achievable by the injured employee's supervisor and submitted to the DPR Workers' Compensation Administrator. *This form will be used in lieu of Form 19.*

- e) **Workers' Comp Refusal of Treatment** – This form should be submitted if the injured employee declines to be medically evaluated.
- f) **CorVel WC Authorization | Physician's Report | Pharmacy Guide** – This form is to be taken by the injured employee to the authorized treating physician and to the pharmacist should medication be prescribed.
- g) **Employee Use of Leave Options** – Supervisors or the WCA will provide all injured employees with this form to complete the information concerning their use of leave options for any time lost from work resulting from an occupational injury. Temporary employees are not eligible for a leave option.
- h) **Workers' Comp Release of Information** – This form authorizes the release of the injured employee's medical records during the claim examination and claim processing procedures.

General: The State of North Carolina is a self-insured carrier. CorVel Corporation is contracted as a third-party administrator to handle claims management. For more information regarding the State of North Carolina's Workers' Compensation Program, go to the NC OSHR website at: [NC OSHR Workers' Comp](#).

Questions and concerns may be directed to the division safety consultant.

Appendix A – Workers' Compensation Forms

Appendix B – Staff Directive 18-07

Appendix A

Workers' Compensation Forms:

[Employee Incident Report](#)

[Supervisor Incident Investigation](#)

[Witness Statement Form](#)

[Injury Data Collection Form](#)

[Workers' Comp Refusal of Treatment](#)

[CorVel WC Authorization | Physician's Report | Pharmacy Guide](#)

[Employee Use of Leave Options](#)

[Employee Release of Information](#)



NORTH CAROLINA EMPLOYEE INCIDENT REPORT

Instructions: Employee must complete report. If more room is needed, continue in a Word document and attach it to this submission.

Employees are required to complete this form for all incidents and near hits. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

Supervisor Review: If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report.

My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Check Not applicable (employee completed form) or sign below if you assisted with the completion of this form.

Supervisor Name:

Signature:

Employee Information

Name (Full):

Date/Location Information

Date of Incident: / / **Time of Day:**

Employee ID #:

Date Reported to

Supervisor: / / **Time of Day:**

Job Title:

Male

Telephone #:

Female

Department:

Work Address:

Agency/University:

Incident Location (address, Building name, office, cross streets, fire name, woods, facility, room #, etc.):

Supervisor:

Phone #:

Date Hired:

Time in Current Job:

County:

Witness Information

Were there any witnesses to the incident? Yes No Number of Witnesses (if applicable): _____

If yes, list all known witnesses/phone #'s below, please include additional names on attachment if needed.

Name:

Phone #:

Name:

Phone #:

Medical Information

Part(s) of the body injured:

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? Yes No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

Description of Accident/Incident

What was the root cause of the incident? Ask why, and then ask why again. (e.g. Why? I slipped on scrap metal. Why? The work area was not cleaned up. Why? I was rushing to get project done and did not take time to clean up the work area.)

Suggested Corrective Actions

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Employee Name

Signature

Date / /



NORTH CAROLINA SUPERVISOR INCIDENT INVESTIGATION REPORT

Instructions: Begin investigation within 24 hours and attach the Employee Incident Report and Witness Reports to this report. Forward all reports within 72 hours to the Program Administrator. If more room is needed, continue in a Word document and attach it to this submission.

Agency/University:	Date of Incident:		
Employee Name:	Employee Phone #:		
Incident Supervisor:	Supervisor Phone #:		
Incident Classifications (check all that apply)			
<input type="checkbox"/> Near Hit <input type="checkbox"/> Injury <input type="checkbox"/> Fatality <input type="checkbox"/> Property Damage <input type="checkbox"/> Spill <input type="checkbox"/> Possible Blood Borne Pathogen exposure			
Employee required:			
<input type="checkbox"/> First-Aid Only <input type="checkbox"/> Medical treatment and released <input type="checkbox"/> Hospitalized <input type="checkbox"/> Other:			
Employee:			
<input type="checkbox"/> Returned to work no restrictions <input type="checkbox"/> Returned to work with restrictions <input type="checkbox"/> Did not return to work (Lost Days)			
Hazard Types (select one based on origination of injury in this preference order)			
<input type="checkbox"/> Violence or injuries caused by people or animals <input type="checkbox"/> Transportation <input type="checkbox"/> Fires or Explosions <input type="checkbox"/> Slips, Trips, Falls Surface Level <input type="checkbox"/> Fall from Elevation <input type="checkbox"/> Exposure to harmful substances or environment <input type="checkbox"/> Contact with objects or equipment (Struck By, Struck Against, Caught-on, Caught between, Puncture, Cut) <input type="checkbox"/> Over-Exertion (lifting) <input type="checkbox"/> Bodily Motion (reaching, twisting, running) <input type="checkbox"/> Other (List Here):			
Names of Witnesses Interviewed:			
Incident Information			
<p>Describe the specific activity the employee was engaged in and the sequence of events. Include objects or substances that directly injured or made the employee ill. Describe tools, equipment, and PPE in use. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)</p>			
Is the activity part of the employee's normal job? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior to beginning activity, did the employee review potential hazards/dangers? <input type="checkbox"/> Yes <input type="checkbox"/> No Date employee last received training for the activity: / /			
<p>What was the root cause of the incident? Ask why then ask why again (e.g. Why? The employee slipped on scrap metal. Why? The work area was not cleaned up. Why? The employee was rushing to get a project done and did not take time to clean up the work area.)</p>			
<p>Action taken or will be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)</p>			
<p>I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.</p>			
Supervisor's Name:	Signature	Date of Report:	/ /
Manager's Name:	Signature	Date Reviewed:	/ /
<p>The Supervisor will obtain the Managers' signature and forward signed copies of the Employee Report, Witness Statements, and the Supervisor's report to the Program Administrator. The Program Administrator will send the Employee's and Supervisor's reports to the Manager's supervisor, Local Safety Contact, Safety Committee Chairperson, and Agency Safety Director within two business days. The WCA will receive all reports and all supporting documentation.</p>			
Program Administrator Name:	Signature	Date	/ /
Date Corrective Actions Completed:			

NORTH CAROLINA SUPERVISOR'S INCIDENT INVESTIGATION REPORT - PAGE 2



ACCIDENT BREAKDOWN BY CHARACTERISTIC (check all that apply)

Nature of Injury	Part of Body Affected
<input type="checkbox"/> Amputation or Enucleation <input type="checkbox"/> Assault <input type="checkbox"/> Burn or Scald <input type="checkbox"/> Contusion, Bruise <input type="checkbox"/> Electric Shock <input type="checkbox"/> Eye, Foreign body in <input type="checkbox"/> Fracture, Broken Bone <input type="checkbox"/> Freezing, Frostbite <input type="checkbox"/> Hearing Loss or Impairment <input type="checkbox"/> Heat Exhaustion, Sunstroke <input type="checkbox"/> Hernia or Rupture <input type="checkbox"/> Infection <input type="checkbox"/> Inhalation Injury-Toxic Substance <input type="checkbox"/> Insect Bites <input type="checkbox"/> Laceration (Cut) <input type="checkbox"/> Multiple Injuries <input type="checkbox"/> Needle Puncture <input type="checkbox"/> Rash, From Plants <input type="checkbox"/> Rash, Not From Plants (Dermatitis) <input type="checkbox"/> Scratches, Abrasions <input type="checkbox"/> Sprain, Strains <input type="checkbox"/> Other	<input type="checkbox"/> No Physical Injury <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes (Including Vision) <input type="checkbox"/> Arm(s) (Above Wrist) <input type="checkbox"/> Hand(s) (Including Wrist) <input type="checkbox"/> Finger(s) and Thumb(s) <input type="checkbox"/> Upper Extremity, Multiple Parts (shoulder, arm, forearm, wrist, or hand) <input type="checkbox"/> Abdomen (Including Internal Organs) <input type="checkbox"/> Back (Including Muscles, Spine) <input type="checkbox"/> Chest (Including Internal Organs) <input type="checkbox"/> Hips (Including Pelvic Organs) <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Trunk, Multiple Parts <input type="checkbox"/> Leg(s) (Above Ankle) <input type="checkbox"/> Foot (Including Ankle) <input type="checkbox"/> Toes <input type="checkbox"/> Lower Extremity, Multiple Parts (from the hip to the toes) <input type="checkbox"/> Multiple Parts of Body, Severe <input type="checkbox"/> Digestive System <input type="checkbox"/> Respiratory System <input type="checkbox"/> Circulatory System <input type="checkbox"/> Skin <input type="checkbox"/> Other
Type of Accidents	Safety Equipment in Use
<input type="checkbox"/> Bodily Reactions (Sprains, Strains, Rupture, Etc.) <input type="checkbox"/> Caught In, Under, Or Between <input type="checkbox"/> Contact With Temperature Extremes (Fire, Cold) <input type="checkbox"/> Disease Exposure <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Falls (All Types) <input type="checkbox"/> Noise Exposure <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Rubbed Or Abraded By Object <input type="checkbox"/> Struck Against Object <input type="checkbox"/> Struck by Flying Object <input type="checkbox"/> Struck by Other Object/Person <input type="checkbox"/> Toxic Materials Exposure <input type="checkbox"/> Vehicle or Equipment Accident <input type="checkbox"/> Other	<input type="checkbox"/> Hard Hat <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Face shield or welder helmet <input type="checkbox"/> Gloves <input type="checkbox"/> Fire Shirt <input type="checkbox"/> Fire Pants <input type="checkbox"/> Safety Shoes <input type="checkbox"/> Fireline Boots <input type="checkbox"/> Ear Protection <input type="checkbox"/> Respirator <input type="checkbox"/> Lanyards & Lifelines <input type="checkbox"/> Fluorescent Vests <input type="checkbox"/> Buoyant Work Vest <input type="checkbox"/> Warning & Control <input type="checkbox"/> Seat Belts <input type="checkbox"/> Shoulder Harness <input type="checkbox"/> Safety Equipment, National Electrical Code (NEC) <input type="checkbox"/> Lab Coat <input type="checkbox"/> Other

When submitting this report, include pictures of incident location, equipment in use, the vehicle used (if applicable), and any third party reports (i.e. Police Report, OSHA Report, etc.).



NORTH CAROLINA WITNESS STATEMENT FORM

Instructions: Before providing the required information below, please note that you will have to certify the truthfulness of this information. You will also be required to acknowledge that you understand that in addition to being disciplined for providing false and/or misleading information, up to and including dismissal, you may also be subjected to additional criminal and/or civil liability. To help you write this statement, please include, if possible, the following information:

Type of Investigation:

Safety Incident Accident Review Near Hit Property Damage

Witness Information

Name:	Title:
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Work Address:	Work Phone #:
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Incident Information

Date of Incident:	Time of Incident:
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Location of Incident:

Do you have any pictures of the incident? Yes No
If yes, please attach them to this submission.

List the names of anyone present who observed or may have knowledge of the incident.

State what you know about the incident. Indicate who, what, where, and when. Be as specific as possible. If you need more space than what is provided here, create a Word document and attach it to this submission.

I hereby certify that the information I have provided is true and accurate. I acknowledge that any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Witness Name:	Witness Title:
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Signature:	Date of Statement: / /
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Injury Data Collection Form

Instructions: Injured employee's supervisor immediately completes form following work related injury and sends to agency staff responsible for reporting work related injury to third party administrator (CorVel) via CareMC web portal.

Employee's name:	Date of Birth:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:		
Home phone:	Work phone:	
Social security number:		
Location where the injury occurred:	What county was employee injured in?	
State Agency:	Division Name:	
Date of injury:	Day of the week:	Hour of the day:
Did injury occur on employer's premises? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was the employee paid for the entire day? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date supervisor knew of the injury:	Name of supervisor:	
Occupation of injured employee:		
Date employee hired:	How long has injured employee been employed?	
Number of hours worked per day:		
Describe fully how injury occurred and what employee was doing at the time of the injury:		
What part and side of the body was injured?		
Did employee return to work? Yes <input type="checkbox"/> No <input type="checkbox"/>	When did employee return to work?	
Was employee treated by a physician? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this a report only with no medical treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Time the employee started work the day of the injury:		
Where did injured employee go for treatment (Facility name, address and phone number)?		
Was this an ER visit? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did injury require an overnight stay? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was the injury caused by another person? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was this due to an assault? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you question the validity of this claim? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If so explain why:		



WORKERS' COMPENSATION REFUSAL OF TREATMENT

DATE: _____

EMPLOYEE: _____

As of the above noted date, I am notifying _____ (agency) of an injury that occurred on (date) _____. This injury was; was not initially reported by me to my supervisor on (date) _____.

This injury (briefly describe condition/body part) _____ did occur while I was employed with the _____ (agency), and while performing my assigned duties.

At this time I have been requested by a representative of _____ (agency) to be medically evaluated by a _____ (agency) preferred healthcare provider. However, I decline to be medically evaluated for the above noted condition. I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the _____ (agency) healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and go to the below listed provider:

PROVIDER: _____

ADDRESS: _____

PHONE: (____) _____

(NOTE: SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE)

I have have not sought medical treatment for this injury from:

TREATING PHYSICIAN'S Phone Number: _____
NAME/ADDRESS (including city & state)

STATEMENT: I have read the above information and it is a factual and true statement. I authorize any physician, hospital or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

Employee signature

Supervisor/witness signature

Date _____

Date _____

EMPLOYER: Please complete the top section and give to the injured employee to take with them to their authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee: Last:	First:
Date of Injury:	
Name of Employer:	
Employer Signature:	Treating Physician:

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The bottom section is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: _____

A post accident drug test (check one) **has** been completed **has not** been completed

In accordance with this patient's physical capability, check all that apply:

- () May resume work immediately, no restriction.
() May resume work immediately with the following restrictions:
 () Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
 () Light work (lifting less than 20 pounds)
 () Medium work (lifting less than 50 pounds)
 () Heavy work (lifting less than 100 pounds)
 () Normal shift
 () Limited hours: _____ hrs, _____ hrs, _____ hrs per day
 () Other:

- () Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	Left	Right
No Use		
Occasional <33% of time		
Frequent 34-66% of time		
Regular 67-100% of time		

- () Patient may return to work at full duty on (date) _____
() Patient has a return appointment on (date) _____ at (time) _____

Please indicate any referrals that are required:

Physician's Signature

Date _____

Physician's Name (type or print)

Physician Offices – Be sure to contact CorVel's Claim Department at 800-365-5998 for authorization for the referral.

PHARMACIST: Please use the Injured Worker's **SSN and Date of Injury (SSN+MMDDYYYY)** as their 17 digit Identification Number when entering information to process an online claim to CorVel on behalf of Department of Environmental and Natural Resources injured employees. Pharmacies can contact the **CorVel Customer Service at 800-563-8438 or CVS/Caremark Pharmacy Help Desk at 877-876-7216**, for assistance with claims processing.

DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION

CHAIN NAME	CHAIN NAME	CHAIN NAME	CHAIN NAME
Bi-Lo Pharmacy	Horizon Pharmacy	Revco drugs	VIX Pharmacy
Bi-Mart	HyVee Drugtown	Rite-Aid drugs	Walgreen's
Brooks Drugs	J & J Pharmacy	RX Discount Pharmacy	Wal-Mart Pharmacy
Brookshire Brothers	Joel & Jerry's	Sack-n-Save	Wegman Pharmacy
Cub Pharmacy	Kash N Karry	Sav-A-Lot	Winn-Dixie
CVS Drugs	Kerr Drugs	Sams Club Pharmacy	
Drug Emporium	K-mart phcy	Save Mart	
Eckerd's(all others)	Long's Phcy	Stop N Shop	
Franck's Pharmacy	Medicine Shoppe	Super D	
Fred Meyer	Medistat Phcy	Super Valu	
Fred's Pharmacy	Milner-Rushing Drugs	Super X (HSI)	
Giant Pharmacy	Pathmark Pharmacy	Tom Thumb Phcy	
Goodings	Perry Drg Str	Tops Pharmacy	
Hannaford Food &	Phar-Mor	Tri Daly Drugs	

Group Number: BXEEWC311

CCRx BIN: 004336

PCN: ADV

Rev. 6/10

Dept. of Environ. & Natural Res.

100

* All participating pharmacies have not been included on this list. Please have your pharmacy call regarding any questions/authorizations 800-563-8438.



EMPLOYEE USE OF LEAVE OPTIONS FORM

The following leave options are available during the seven (7) day waiting period to receive temporary total disability (TTD) benefits for an injured employee that loses time from work as a result of an on-the-job injury that is determined by their employing agency to be compensable.

Check one of the options below to elect leave usage for the seven (7) day waiting period.

- Option 1:** Elect to take sick or vacation leave during the required seven-day waiting period and then go on workers' compensation leave and begin drawing workers' compensation weekly benefits.
- Option 2:** Elect leave without pay for the seven-day waiting period and then began drawing workers' compensation weekly benefits.

Note: In either option above if the injury results in disability of more than 21 days, the workers' compensation weekly benefit shall be allowed from the date of the disability.

Check one of the options below to elect the option to supplement workers' compensation payments after the seven (7) day waiting period.

- Option 1:** Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Human Resources. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation.
- Option 2:** Elect workers' compensation payments without supplemental leave usage.

Note: All elections involving use of earned sick or vacation leave are subject to their availability at the time of the injury.

By signing below, I certify that in the event of any overpayment of wages or workers' compensation benefits, such amounts shall be deducted from future benefits owed or immediately repaid in cash by the employee. This election may only be changed by completing a new form.

Employee Name (print)

Date of Injury

Employing Agency

Division/Unit

Employee Signature

Date

Supervisor Completes This Section

The above named employee was injured on _____ and was placed on workers' compensation leave effective _____ . I completed an Incident Investigation Report for this injury and submitted it to my agency's workers' compensation administrator along with all information necessary to complete the Industrial Commission Form 19, Employer's Report of Employee's Injury of Occupational Disease to the Industrial Commission.

Supervisor Name (print)

Title

Supervisor Signature

Date



Workers' Compensation
STATE HUMAN RESOURCES

EMPLOYEE RELEASE OF INFORMATION MEDICAL AND CLAIM RECORDS

To Whom It May Concern:

My employer filed an Employer's Report of Employee's Injury to the North Carolina Industrial Commission (Form 19) for an injury I reported that occurred on _____.

(insert date of injury)

My employer participates in the North Carolina State Government Workers' Compensation Program administered by the NC Office of State Human Resources.

I understand that claim examination and claim processing procedures shall require release of certain information regarding this claim for distribution, as necessary, to the North Carolina Industrial Commission, state contractors, agencies, healthcare providers and other individuals.

Therefore, I hereby authorize release of any and all information for review, examination, copying and distribution regarding:

1. Pre-existing or current medical/mental health condition(s), pre-existing or current medical/mental health treatment(s), or any other medical/mental health treatment related to this claim.
2. Any previous workers' compensation injuries or claims whether reported or not to the North Carolina Industrial Commission, or any other State or Federal agency.

I understand state contractors, agencies, healthcare providers and other individuals may communicate this information by any reasonable means, including written or telephonic communication or by direct interview, whether or not I am present during or notified of such communications, and I authorize, to initiate and conduct such communications whether or not I am present or have notice thereof.

I understand that this information will be kept strictly confidential unless legal requirements necessitate its release and will be gathered solely for purposes related to this workers' compensation claim.

An electronic or faxed copy of this document shall have the same effect as the original.

Employee Name (Print)

Employing Agency

Employee Signature

Supervisor or Witness Signature

Date

Date

Appendix B

NC DIVISION OF PARKS AND RECREATION

December 14, 2018

STAFF DIRECTIVE 18-07

TO: All Staff

FROM: Dwayne Patterson, Director

SUBJECT: Accident / Incident Chain of Notification / OSHA Reporting for Fatalities and Injuries

This staff directive supersedes previous accident / incident chain of notification reporting procedures, and is effective immediately.

In the event of an employee or visitor accident or incident involving serious personal injury, major criminal activity, significant natural resource damage, media coverage or anything judged by the Park Superintendent to necessitate Division management notification, the Park Superintendents or their designee (*this includes Acting Park Superintendents or Rangers In-Charge in the event the Superintendent is unavailable to make the notification*), shall contact their Regional Superintendent (RESU) by phone as soon as possible. If the RESU cannot be reached in a timely manner, the Superintendent of State Parks (SUSP), or other senior DPR staff shall be notified by phone. Upon notification, the Regional Superintendent or designee shall contact the Superintendent of State Parks via telephone. The SUSP or designee shall then contact the Division Director, Deputy Director and the Division Public Information Officer (PIO).

If a person listed in the chain of notification cannot be reached, the next person in the chain shall be contacted. If the Division's SUSP, PIO, Deputy Director, Director or PACR cannot be reached, the ranking Division employee shall contact the DNCR Chief Deputy Secretary. In most circumstances, the Division Director, Deputy Director or SUSP will make notifications to the DNCR Chief Deputy Secretary and/or Secretary.

In the event of a serious occupational accident or injury-including near misses involving an employee, or an employee fatality, notification shall be made immediately to the Division Director through the chain of notification and the standard reporting procedures should be followed for the reporting of fatalities and injuries to OSHA.

On weekends, holidays, and after 5:00 pm on weekdays, OSHA notification for fatalities or serious employee accidents involving employee in-patient hospitalization, amputation or eye loss should be made to the State Capitol Police at 919-733-3333. State Capitol Police will log the report and contact the OSHA's on-call person. The Division shall follow up with a report to the Department and OSHA on the next business day for those cases reported to the State Capitol Police on weekends, holidays, and after work hours.

Attachment (Chain of Notification)

NC DIVISION OF PARKS AND RECREATION

QUICK REFERENCE - ACCIDENT/INCIDENT CHAIN OF NOTIFICATION

DIVISION – Headquarters Main Line – 919-707-9300				Updated 12/14/18
TITLE	NAME	OFFICE PHONE	MOBILE	ALTERNATE
Director	Dwayne Patterson	919-707-9333	919-210-8919	-
Deputy Director	Carol Tingley	919-707-9334	919-810-3436	-
Assistant Director	Don Reuter	919-707-9357	919-621-8961	919-848-2399
Superintendent of State Parks	Adrian O’Neal	919-707-9339	919-738-4534	919-738-4534
Public Information Officer	Katie Hall	919-707-9350	919-817-3752	919-601-0616
Coastal Region Superintendent	John Fullwood	919-778-9488	252-559-0914	252-241-0464
Piedmont Region Superintendent	Jay Greenwood	919-841-4059	919-608-2847	252-715-1489
Mountain Region Superintendent	Sean McElhone	704-528-6514	704-682-4028	828-803-5700
DIVISION LAW ENFORCEMENT / SAFETY				
Parks Chief Ranger	Bryan Dowdy	919-707-9340	919-218-7484	919-676-3890
Law Enforcement Specialist	Chris Fox	919-707-9343	919-606-8481	919-815-0262
DPR Safety Consultant	Keith Bilger	919-707-9372	919-632-8322	-
State Capitol Police	Alarms & OSHA notification after hours	919-733-3333	-	-
NC State Bureau of Investigation (SBI)	Raleigh Headquarters	919-662-4500	800-334-3000	-
DEPARTMENT (DNCR)				
DNCR Secretary	Susi H. Hamilton	919-807-7250	-	-
DNCR Chief Deputy Secretary	Reid Wilson	919-807-7257	919-604-6241	-
DNCR Director of Communications	Neel Lattimore	919-807-7388	202-497-1900	-
DNCR Safety Director	John Mullinax	919-807-7456	-	-