	DEPARTMENT OF SOCIAL SERVICES AND HOUSING CORRECTIONS DIVISION POLICIES & PROCEDURES MANUAL	EFFECTIVE DATE: FEB 7 1986	POLICY NO.: 493.01.10
		CHAPTER NO.: 1	SUPERSEDES NO.: 5000-Accidents DATE:
	SUBJECT: ACCIDENTS AND WORKER'S COMPENSATION CLAIMS		Page 1 of 4

1.0 PURPOSE

To delineate procedures which shall be followed in the reporting of accidents and the filing of worker's compensation claims.

2.0 REFERENCES AND DEFINITIONS

.1 References

a. Comptroller's Memorandum, 1985-21

b. DSSH, Director's ICF dated, 7-9-85

c. DSSH Policies and Procedures, 5.6.0.02, Accidents involving State Motor Vehicles

.2 Definitions

a. "Work Period" shall mean the normal eight hour shift or watch period to which an employee is assigned, plus any overtime required on that same shift or watch.

3.0 POLICY

All employees of the Corrections Division shall maintain and operate equipment and facilities in safe conditions at all time in order to prevent the occurrence of accidents. In the event of accidents, reporting shall be done in a timely and efficient manner.

.1 State employees on Oahu injured in any way while performing assigned duties shall:

a. Complete and sign four (4) copies of Form WC-5, "Employee's Claim for Compensation," as soon as possible after the injury.

b. The employee's supervisor shall complete and submit four (4) copies of WC-1, "Employer's Report of Industrial Injury," during the work period involved.

c. In the event the employee needs the services of a physician, four (4) copies of Form WC-2," Attending Physician's First Report," shall be completed and submitted.

d. All copies of the required forms shall be forwarded immediately to the Corrections Division Office.

.2 State employees on the Neighbor Islands shall:

a. Prepare the same number of copies, within the same time periods, as stated above in .1 a-d.

b. Send the original of Form WC-5, "Employee's Claim for Compensation," Form WC-1, "Employer's Report of Industrial Injury," and For, WC-2, "Attending Physician's First Report," to the Worker's Compensation Office on their respective island.

c. Forward the remaining three (3) carbon copies to the Corrections Division Office.

d. Carrier's Case Report, Form WC-3, shall be completed by the Department's Fiscal Office after all of the necessary papers have been completed, determination made and award received. The Corrections Division Office will then send a completed set of papers to the employee involved.

.3 If employees do not require the services of a physician, they shall complete four (4) copies of WC-5, "Employee's Claim for Compensation," and the supervisor shall complete four (4) copies of Form WC-1, "Employer's Report of Industrial Injury," indicating at the top left-hand corner of the forms "FOR RECORDS ONLY" to close the case. On Oahu forward four (4) copies to the Corrections Division office. On Hawaii, Kauai, and Maui send the original to the Worker's Compensation office of the respective island and forward the remaining three (3) copies to the Corrections Division office.

.4 Supervisor Accident Report, Form DSSH 0124, (10/84), shall be compiled by the Branch safety representative for all accidents regardless of employee injury or not and forwarded to the Department Safety Officer via the Corrections Division Personnel Clerk.

.5 Other procedures not withstanding, the Departmental Safety Officer requires 24 hours notification on all employee injuries in order to expedite that office's processing of the case. Where necessary reports are expected to be delayed beyond that time limit, telephone notification is needed.

.6 Any inmate, ward or juvenile parolee under the jurisdiction of the Corrections Division who becomes injured shall have completed for them two (2) copies of Form DSSH 3821 (12/85), "Inmate or Parolee Injury Report," within 24 hours after the injury. The original shall be filed in the active file of the inmate or parolee and the remaining copy shall be forwarded to the Corrections Division office.

.7 Any collision, upset or property damage resulting from the operation of any State-owned vehicle shall be reported on ASC 309 R 22, "Automobile Accident Report," within the work period involved.

a. Three (3) complete copies shall be forwarded immediately to the Corrections Division office. (Refer to ADS/FIS on insurance carrier instructions.)

b. Any incident that results in death, major injury or major property damage shall be reported immediately to the Corrections Division Administrator and

Alexsis Risk Management, Inc.
1221 Kapiolani Blvd., Suite 901
Honolulu, Hawaii 96814

Phone (808) 531-2011 or 544-1397

c. In case of an accident on Oahu, the driver and his supervisor should be guided by the following procedure:

1) Driver should use the accident report card, fill out the details of the accident at the scene and give it to his supervisor or business office as soon as possible during the work period. He should report personal injury or serious property damage to his supervisor at once by phone.

2) It is the supervisor or business office's (whichever is notified) responsibility to report the accident immediately by phone to the claims department of Alexsis Risk Management, Inc.

3) A written report must follow within five (5) working days using standard accident forms, ACORD-Automobile Loss Notice, furnished by the insurance company. Send the original and two (2) copies to ADS/FIS.

4) State employees using DAGS, Motor Pool Vehicles are requested to follow Section 17c, "Accident Reports" of DAGS, Central Motor Pool Rules and Regualtions in reporting accidents instead of the procedure outlined above.

d. For accidents occurring on the Neighbor Islands employees should be guided by the following procedure:

1) Driver should use the accident report card to fill in the details of the accident at the scene and submit it to his supervisor or business office as soon as possible during the work period. He should report personal injury or

serious property damage to his supervisor at once by phone. The supervisor shall inform Alexsis Risk Management, Inc. immediately by phone of the accident and personal injury.

2) For minor accidents without injury, submit the original and two (2) copies of the accident report (standard forms) by mail to ADS/FIS. The claims representative may contact you by phone to give instructions and inform the claimant of their approved repair shop on your island.

3) For all major accidents (especially where injury is incurred) call Alexsis Risk Management, Inc. claims department by phone. Tell the operator to reverse the toll charge. Your completed accident report must follow by mail within five (5) working days.

On week-ends have the operator advise the answering service that it is an emergency and that you are representing the State of Hawaii. (Excerpt from Comptroller memo of June 26, 1985)

e. If necessary, a claim adjuster may be sent from Honolulu. The limits of liability of the State's Auto Fleet Self-Insured Liability Program are:

a. Bodily Injury Liability -

$300,000 on each person

b. Property damage - $50,000 limit each accident

4.0 SCOPE

This policy applies to all Corrections Division personnel.

Approved Ted Sakai
Division Administrator

2/3/86
Date

Approved Franklin J. Sullivan
Director

2-7-86
Date

STATE OF HAWAII
DEPARTMENT OF SOCIAL SERVICES AND HOUSING

CORRECTIONS DIVISION

Office Use
Non-Disabling ☐
Disabling (lost-time) ☐

INMATE OR PAROLEE INJURY REPORT

NAME OF INJURED			SEX	AGE
OCCUPATION			SOCIAL SECURITY NO.	
DEPARTMENT	DIVISION	BRANCH	UNIT	
LOCATION		DATE AND TIME OF INJURY		
NATURE OF INJURY				

Description of Accident

1. What job was inmate doing including tools, machine and materials used? (Example: lifting a heavy casting onto a four-wheel truck.)

2. How was inmate injured? (Example: The casting slipped from his grasp and fell on his toes.)

3. What did inmate do unsafely? (Example: Tried to lift too heavy a load.)

4. What was defective, in unsafe condition, or wrong with method? (Example: Should have had help.)

5. What safeguards should be used? (Example: Wear safety shoes.)

6. What steps were taken to prevent similar injuries? (Example: Instructed men to assist each other in lifting heavy loads.)

7. What other steps should be taken to prevent a recurrence? (Example: Provide mechanical handling equipment for this work.)

8. This contains information necessary to explain in detail the accident and/or injury and medical aid administered and by whom.

SIGNATURE OF WARD OR INMATE	SIGNATURE OF SUPERVISING EMPLOYEE

DSSH-3821(12/85)

STATE OF HAWAII
Department of Social Services and Housing

SUPERVISOR ACCIDENT REPORT

Injured Employee's Name _____ Social Security No. _____

Occupation/Position _____ Length of Service _____ yrs. (present position)

Date/Time of Injury _____ / _____

Nature of Injury _____

_____

[ ] Disabling (Time Lost)
[ ] Medical Expenses Involved
[ ] First-Aid Only
[ ] Non-Disabling
[ ] No Medical Expenses Involved
[ ] Other _____

Description of Accident

1. How or why did accident occur?

2. How was employee injured?

3. What unsafe conditions/acts contributed to the accident?

4. What steps were taken to prevent a recurrence of the accident?

5. Were there witnesses to the accident? If so, please list their names, and attach their statements.

6. Was employee using proper safety equipment? Yes _____ No _____

7. Was safety equipment available at the worksite? Yes _____ No _____

_____
Supervisor's Signature Date

Department/Division/Area _____

DSSH 0124 (10/84)

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

FORM WC-5
(REV. 11/78)

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

INJURED PERSON

Name _____

Address _____

Occupation _____

Phone No. _____ Social Security No. _____

EMPLOYER

Name _____

Address _____ Phone No. _____

Nature of Business _____

INSURANCE CARRIER

Name _____

Address _____

INJURY

Date of Accident _____ Time _____ Date Disability Began _____

If not on employer's premises, place where accident occurred _____

_____

How did accident occur _____

_____

Reason for filing:

- ☐ Employer has not filed WC-1
- ☐ Insurance carrier has not paid benefits
- ☐ Reopening of old claim
- ☐ Others. Specify: _____

WITNESS

Name _____

Address _____

NOTICE

Did you give employer notice of injury? ☐ Yes ☐ No

If so, when: _____ How: ☐ Oral ☐ Written

To whom: _____

ATTENDING PHYSICIAN

Name _____

Address _____

I hereby present my claim for compensation for disability resulting from the foregoing injury arising out of and in the course of my employment and not caused by my intoxication nor by my wilful intention to injure myself or another.

I hereby authorize any physician and/or hospital to release any information related to any treatment rendered me.

Represented By _____
DATE

_____
SIGNATURE OF CLAIMANT

Address _____

Date _____

...ine or imprisonment for 30 days. (Sec. 386-93, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

furnish the injured employee a copy of this report.

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

(NOTE: DO NOT WRITE IN SHADED BLOCKS)

CASE NUMBER

IDENTIFICATION SECTION

EMPLOYEE NAME - LAST | FIRST | MI | SOC SEC NO | DATE OF BIRTH MO / DAY / YR | SEX ☐ MALE ☐ FEMALE | MARITAL STATUS MARRIED ☐ SINGLE ☐ | DATE RECEIVED MO / DAY / YR

ADDITIONAL ADDRESS INFORMATION | CITY | STATE | ZIP CODE

PHONE | OCCUPATION | HOW LONG EMPLOYED BY YOU AT THIS OCCUPATION? | YRS EMPO CODE | DEPARTMENT | PAYROLL COMP CLASS CODE | OCC CODE

EMPLOYER NAME | ADDRESS | CITY | STATE | ZIP CODE

PHONE | NATURE OF BUSINESS | DATE INJURY ILLNESS REPORTED MO / DAY / YR | DATE OF INJURY ILLNESS MO / DAY / YR | PREFAB ☐ WC-2 ☐ WC-5 | DOL NUMBER | AKA

DETAILS OF INJURY/ILLNESS

TIME OF INJURY/ILLNESS _____ A M _____ P M | TIME OF WK CODE | PLACE OF I.I. IF DIFFERENT FROM EMPLOYERS MAILING ADDRESS | CITY | STATE | ON EMPLOYER'S PREMISES ☐ YES ☐ NO | SIC | OWNERSHIP CODE

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.)

SOURCE OF INJURY | ACCIDENT TYPE

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)

TASK | ACTIVITY | ACCIDENT FACTOR

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin. In case of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY ILLNESS AND PART OF THE BODY AFFECTED

	YES	NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT	☐	☐		
BURNS	☐	☐		

TIME LOST INFORMATION

DISABILITY BEGAN MO / DAY / YR | WAS EMPLOYEE FURNISHED MEALS OR LODGING? ☐ YES ☐ NO | AVG WKLY WAGE | IF EMPLOYEE IS BACK TO WORK GIVE DATE MO / DAY / YR | WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS? ☐ YES ☐ NO | IF EMPLOYEE DIED GIVE DATE MO / DAY / YR | HOURLY WAGE | MONTHLY SALARY | HRS. WKED PER WK | WEIGHING FACTOR

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN | ADDRESS | PHYSICIAN I D CODE

NAME OF HOSPITAL (IF HOSPITALIZED) | ADDRESS

INSURANCE

NAME OF WC INSURANCE COMPANY | NAME OF INSURANCE AGENCY | IF LIABILITY DENIED - WHY? | IS LIABILITY DENIED? ☐ YES ☐ NO

POLICY PERIOD | AGENT CODE | CARR CASE NO.

SIGNATURE

TITLE | DATE MO / DAY / YR

$100 fine or imprisonment for 90 days. (See. 386-93, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

(NOTE: DO NOT WRITE IN SHADED BLOCKS)

CASE NUMBER

IDENTIFICATION SECTION

EMPLOYEE NAME - LAST | FIRST | MI | SOC SEC NO | DATE OF BIRTH MO / DAY / YR | SEX ☐ MALE ☐ FEMALE | MARITAL STATUS MARRIED ☐ SINGLE ☐ | DATE RECEIVED MO / DAY / YR

ADDITIONAL ADDRESS INFORMATION | CITY | STATE | ZIP CODE

PHONE | OCCUPATION | HOW LONG EMPLOYED BY YOU AT THIS OCCUPATION? | YRS EMPD CODE | DEPARTMENT | PAYROLL COMP CLASS CODE | OCC. CODE

EMPLOYER NAME | ADDRESS | CITY | STATE | ZIP CODE

PHONE | NATURE OF BUSINESS | DATE INJURY ILLNESS REPORTED MO / DAY / YR | DATE OF INJURY ILLNESS MO / DAY / YR | PREFAB ☐ WC-2 ☐ WC-5 | DOL NUMBER | AKA

DETAILS OF INJURY/ILLNESS

TIME OF INJURY/ILLNESS _____ A.M _____ P.M | TIME OF WI CODE | PLACE OF I.I IF DIFFERENT FROM EMPLOYERS MAILING ADDRESS | CITY | STATE | ON EMPLOYER'S PREMISES ☐ YES ☐ NO | SIC | OWNERSHIP CODE

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.)

SOURCE OF INJURY | ACCIDENT TYPE

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)

TASK | ACTIVITY | ACCIDENT FACTOR

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin, in case of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY ILLNESS AND PART OF THE BODY AFFECTED

	YES	NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT	☐	☐		
BURNS	☐	☐		

TIME LOST INFORMATION

E DISABILITY BEGAN D / DAY / YR | WAS EMPLOYEE FURNISHED MEALS OR LODGING? ☐ YES ☐ NO | AVG WKLY WAGE | IF EMPLOYEE IS BACK TO WORK GIVE DATE MO / DAY / YR | WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ ILLNESS? ☐ YES ☐ NO | IF EMPLOYEE DIED GIVE DATE MO / DAY / YR | HOURLY WAGE | MONTHLY SALARY | HRS WKED. PER WK | WEIGHTING FACTOR

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

AME OF PHYSICIAN | ADDRESS | PHYSICIAN I D CODE

AME OF HOSPITAL (IF HOSPITALIZED) | ADDRESS

INSURANCE

AME OF WC INSURANCE COMPANY | NAME OF INSURANCE AGENCY | IF LIABILITY DENIED - WHY? | IS LIABILITY DENIED? ☐ YES ☐ NO

POLICY PERIOD | AGENT CODE | CARR. CASE NO.

IGNATURE

TITLE | DATE MO / DAY / YR

NOTE: DO NOT WRITE IN SHADED BLOCKS)

EMPLOYER NAME AND ADDRESS

CARRIER'S NAME AND ADDRESS

DATE THIS REPORT RECEIVED
MO. / DAY / YR.

	YES	NO
1. ARE YOU THE ATTENDING PHYSICIAN?	☐	☐
2. HAS THE PATIENT BEEN BURNED?	☐	☐
3. IS THERE A POSSIBILITY OF OTHER DISFIGUREMENT?	☐	☐
4. DO YOU THINK PHYSICAL REHABILITATION WILL BE NECESSARY?	☐	☐
5. DO YOU THINK MEDICAL REHABILITATION WILL BE NECESSARY?	☐	☐

PATIENT NAME AND ADDRESS

YOUR NAME, ADDRESS AND TELEPHONE

PATIENT SOCIAL SECURITY NO.	DATE FIRST TREATMENT	DATE OF INJURY/ILLNESS	PHYSICIAN'S I.D.	IF PATIENT DIED, GIVE DATE
	MO. / DAY / YR.	MO. / DAY / YR.		MO. / DAY / YR.

STATE IN PATIENT'S OWN WORDS WHERE AND HOW ACCIDENT OCCURRED:

GIVE ACCURATE DESCRIPTION AND EXTENT OF INJURY: SPECIFY ALL PARTS OF BODY INVOLVED AND STATE OBJECTIVE FINDINGS.

ACCIDENT MENTIONED ABOVE THE ONLY CAUSE OF PATIENT'S CONDITION? ☐ YES ☐ NO; STATE CONTRIBUTING CAUSES.

WHO ENGAGED YOUR SERVICES?

S FURTHER TREATMENT REQUIRED? ☐ NO ☐ YES; HOW LONG?
VERE X-RAYS TAKEN? ☐ NO ☐ YES BY WHOM? DATE(S)
-RAY DIAGNOSIS:

VAS PATIENT TREATED BY ANYONE ELSE? ☐ NO ☐ YES. BY WHOM? DATE(S)
VAS PATIENT HOSPITALIZED? ☐ NO ☐ YES DATE OF ADMISSION: DATE OF DISCHARGE:
AME AND ADDRESS OF HOSPITAL:

ESCRIBE SUBSEQUENT TREATMENT BY YOU:

D ACCIDENT RESULT IN DISABILITY FOR WORK? ☐ YES ☐ NO DATE DISABILITY BEGAN:
TIENT ☐ WAS ☐ WILL BE ABLE TO RESUME ☐ LIGHT WORK ☐ REGULAR WORK ON:

TIENT STOPPED TREATMENT WITHOUT ORDERS ON PATIENT DISCHARGED AS CURED ON:

ESCRIBE ANY PERMANENT DEFECT OR DISFIGUREMENT (INCLUDE SCARS, DISCOLORATIONS, DEFORMITIES, ETC.) ☐ NONE

AL DIAGNOSIS:

PHYSICIAN SIGNATURE DATE