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.


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 notwithstanding, 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

Alexis 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 Alexis 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 Regulations 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 Alexis 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 Alexis 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

Division Administrator

2/3/86

Date

Approved

Director

2-7-86

Date
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.
Date/Time of Injury ___________________________ / ___________________________ (present position)
Nature of Injury ______________________________________

[ ] Disabling (Time Lost) [ ] Non-Disabling
[ ] Medical Expenses Involved [ ] No Medical Expenses Involved
[ ] First-Aid Only [ ] 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)
**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 I received me.

Represented By ____________________________ Date ____________________________

Address ____________________________

Signature of Claimant ____________________________ Date ____________________________
**WC-1 Employer's Report of Industrial Injury**

**Identification Section**

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Last</th>
<th>First</th>
<th>M</th>
<th>SOC Sec No</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Married</th>
<th>Single</th>
<th>Date Received</th>
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**Additional Address Information**

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<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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**Phone**

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<tr>
<th>Occupation</th>
<th>EMP Code</th>
<th>Department</th>
<th>Payroll Comp Class Code</th>
<th>OCC Code</th>
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**Employer Name**

<table>
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<tr>
<th>Address</th>
<th>CITY</th>
<th>State</th>
<th>Zip Code</th>
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**Phone**

<table>
<thead>
<tr>
<th>Nature of Business</th>
<th>Date Injury Illness Reported</th>
<th>Date of Injury Illness</th>
<th>PREPAB</th>
<th>DOL Number</th>
<th>AKA</th>
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**Details of Injury/Illness**

**Type of Injury/Illness**

<table>
<thead>
<tr>
<th>TIME OF TD CODE</th>
<th>PLACE OF INJURY/I ILLNESS DIFFERENT FROM EMPLOYER'S MAILING ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ON EMPLOYER'S PREMISES</th>
<th>EMPLOYER'S OCCUPATION</th>
<th>EMPLOYER'S OCCUPATION</th>
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**How Did This Accident Occur?**

(Describe fully the events that resulted in injury or occupation. The accident occurred, how it happened, what happened next, etc.)

**What Was Employee Doing When Injured?**

(Describe fully the nature of the injury and the equipment or material the employee was using.)

**Source of Injury**

<table>
<thead>
<tr>
<th>TASK</th>
<th>ACTIVITY</th>
<th>ACCIDENT FACTOR</th>
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**NATURE OF INJURY**

(Describe in detail the nature of the injury and any part of the body affected.)

**Disability Began**

<table>
<thead>
<tr>
<th>DISABILITY Began</th>
<th>HOURS EMPLOYEE FURNISHED MEALS OR LODGING</th>
<th>AVG DAILY HOURS</th>
<th>IF EMPLOYEE IS BACK TO WORK DATE</th>
<th>WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY ILLNESS</th>
<th>IF EMPLOYEE DIED DATE</th>
<th>GIVE NAME AND ADDRESS OF SURVIVORS ON BACK</th>
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**Treatment**

<table>
<thead>
<tr>
<th>OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE</th>
<th>PHYSICIAN'S CODE</th>
<th>PHYSICIAN'S ADDRESS</th>
<th>HOSPITALIZE</th>
<th>HOSPITAL CODE</th>
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**Insurance**

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<thead>
<tr>
<th>NAME OF INSURANCE COMPANY</th>
<th>NAME OF INSURANCE AGENCY</th>
<th>LIABILITY DEEMED WHY</th>
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**Nature**

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</table>
**IDENTIFICATION SECTION**

- **Employee Name - Last**: [Redacted]
- **First**: [Redacted]
- **Social Security No**: [Redacted]
- **Date of Birth**: [Redacted]
- **Sex**: [Redacted]
- **Marital Status**: [Redacted]
- **Date of Incident**: [Redacted]
- **Date Received**: [Redacted]

**ADDITIONAL ADDRESS INFORMATION**

- **City**: [Redacted]
- **State**: [Redacted]
- **ZIP Code**: [Redacted]

**EMPLOYER NAME**

- **Address**: [Redacted]
- **City**: [Redacted]
- **State**: [Redacted]
- **ZIP Code**: [Redacted]

**PHONe**

- **NATURE OF BUSINESS**: [Redacted]
- **DATE INJURY/ILLNESS REPORTED**: [Redacted]
- **DATE OF INJURY/ILLNESS**: [Redacted]
- **PREFAB**: [Redacted]
- **SOC NUMBER**: [Redacted]

**DETAILS OF INJURY/ILLNESS**

- **TIME OF INJURY/ILLNESS**: [Redacted]
- **TIME OF INJ**: [Redacted]
- **PLACE OF INJ**: [Redacted]
- **DIFFERENT FROM EMPLOYER'S MAILING ADDRESS**: [Redacted]
- **City**: [Redacted]
- **State**: [Redacted]
- **ON EMPLORER'S PREMISES**: [Redacted]
- **SOCIAL SECURITY NO**: [Redacted]

**SOURCE OF INJURY**

- **ACCIDENT TYPE**: [Redacted]

**WHAT WAS EMPLOYEE DOING WHEN INJURED?**

- **Task**: [Redacted]
- **Activity**: [Redacted]
- **ACCIDENT FACTOR**: [Redacted]

**SUBSTANCE OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE**

- **Description**: [Redacted]

**TIME LOST INFORMATION**

- **Disability Begins**: [Redacted]
- **WAS EMPLOYEE FURNISHED MEALS OF LODGING?**: [Redacted]
- **AVG DIARY WAGE**: [Redacted]
- **IF EMPLOYEE IS BACK TO WORK GIVE DATE**: [Redacted]
- **WAS EMPLOYEE PAID OR FULL FOR DAY OF INJURY ILLNESS**: [Redacted]

**TREATMENT**

- **Name of Treating Physician**: [Redacted]
- **Address**: [Redacted]
- **Physician's Code**: [Redacted]

**INSURANCE**

- **Name of Insurance Agency**: [Redacted]
- **If Liability Denied, Why?**: [Redacted]

**SIGNATURE**

- **Title**: [Redacted]
- **Date**: [Redacted]
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.

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

WHO ENGAGED YOUR SERVICES?

IS FURTHER TREATMENT REQUIRED? ☐ NO ☐ YES; HOW LONG?

WERE X-RAYS TAKEN? ☐ NO ☐ YES BY WHOM?

X-RAY DIAGNOSIS:

DATE(S)

WAS PATIENT TREATED BY ANYONE ELSE? ☐ NO ☐ YES BY WHOM?

WAS PATIENT HOSPITALIZED? ☐ NO ☐ YES DATE OF ADMISSION:

NAME AND ADDRESS OF HOSPITAL:

DATE OF DISCHARGE:

DESCRIBE SUBSEQUENT TREATMENT BY YOU:

DATE DISABILITY BEGAN:

REGULAR WORK ON:

PATIENT DISCHARGED AS CURED ON:

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

PHYSICIAN SIGNATURE

DATE