

2013.01 Incident/Accident Reporting Policy



This procedure is for internal use only and does not enlarge an employee's civil liability in any way. The procedure should not be construed as creating a higher duty of care, in an evidentiary sense, with respect to third party civil claims against employees. A violation of this procedure, if proven, can only form the basis of a complaint by this department for non-judicial administrative action in accordance with the laws governing employee discipline.

Related Policies: Chief's Memo. 2006-004, Incident Accident Report, 2015-059, Hawaii County Incident Accident Report.

Applicable HI Statutes:

I. PURPOSE

To provide clear and consistent procedures for reporting and managing work-related incidents and accidents within the Hawaii Fire Department to ensure timely documentation, compliance, and employee well-being.

II. APPLICABILITY

This SOP applies to all employees, supervisors, and relevant personnel of the Hawaii Fire Department.

III. DEFINITIONS

- Incident: An event requiring first aid or no medical treatment
- Accident: An event requiring medical treatment beyond first aid.
- Amendment of Classification: When an incident evolves into an accident, the classification must be updated.

IV. PROCEDURE

A. Reporting an Incident/Accident:

1. Immediate Reporting
 - a. Employees must report all incidents/accidents to their immediate supervisor before the end of their work shift.
2. Completion of Report:
 - a. The immediate supervisor must complete the Hawaii County Incident/Accident Report (Form HFD-IAR) thoroughly, legibly, and accurately.
 - b. Include detailed descriptions in Sections 17 (Event Details), 18 (Hazardous Conditions), 20 (Prevention Measures), and 21 (Actions to Prevent Recurrence).
 - c. Obtain signatures from all required parties (Employee, Supervisor, Division Head, Department Head).
3. Submission Deadline:
 - a. Submit the completed report to the Administration Office within three working days. Attach a completed WC-1 form if medical treatment was rendered.

B. Classification Updates:

1. When an Incident Becomes an Accident:
 - a. Employees must notify the Personnel Management Specialist immediately upon scheduling medical treatment.



- b. Provide the following details:
 - c. Name of the treating physician.
 - d. Date and time of the appointment.
 - e. Details of the injury/illness.
 - f. Reason for seeking medical treatment
2. Notification Chain:
 - a. The employee informs their immediate supervisor.
 - b. The supervisor notifies the Battalion Chief, who records the update in the daily log and informs the Assistant Fire Chief.
 - c. The employee updates the Personnel Management Specialist and immediate supervisor after the medical appointment with the return-to-work date, if applicable.
- C. Tracking and Leave Management:
 1. Monitoring Leave:
 - a. Supervisors track employees' leave balances and confirm available hours upon request.
 2. Workers Compensation:
 - a. Absences due to work-related injuries/illnesses are charged to the employee's accrued sick leave until the Workers' Compensation claim is approved. Leave balances will be reinstated upon approval.
 3. Exhausting Leave Balances:
 - a. Employees must submit a written request to the Fire Chief for the following options:
 - i. Use accrued vacation hours.
 - ii. Utilize compensatory time-off.
 - iii. Be placed on "leave without pay" status.
- D. Supervisor and Battalion Chief Responsibilities
 1. Verification:
 - a. Ensure reports are complete, signed, and submitted on time.
 2. Notification:
 - a. Immediately notify the Battalion Commander or Bureau Commander for incidents resulting in absence from duty.
 - b. Battalion Commanders route weekend/holiday reports to the appropriate district office.
 3. Division and Department Heads:
 - a. Conduct thorough reviews of reports to ensure accuracy and compliance.

Attachments:

1. Hawaii County Incident/Accident Report.
2. WC-12 Election of Compensation Form

--End--

HAWAI‘I COUNTY INCIDENT/ACCIDENT REPORT

Circle **INCIDENT** if Employee did not seek medical treatment.

Circle **ACCIDENT** if Employee sought medical treatment.

----- PLEASE PRINT -----

1. Employee Name (Last, First, MI) Phone No.: _____		2. Department / Division & District		3. Employee No.			
4. Job Title / Position		5. Time of incident/accident		6. Date of incident/accident			
7. Date reported		8. Did Employee lose time from work other than the date of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		9. Date returned to work			
10. Location of incident/accident		11. Did Employee complete shift? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. Nature of injury/illness (cut, sprain, etc.)			
13. Part(s) of the body injured (right/left knee, etc.)							
Location/Side of Injury/Illness				Part of Body			
A.	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Front	<input type="checkbox"/> Back			
B.	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Front	<input type="checkbox"/> Back			
C.	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Front	<input type="checkbox"/> Back			
14. Treating Physician (Write "None" if no medical treatment provided)							
15. What was Employee doing at the time of the incident/accident?				PERSONAL PROTECTIVE EQUIPMENT			
					Issued	Used	
16. What equipment, machine or tools were being used?				A. Hard Hat	<input type="checkbox"/>	<input type="checkbox"/>	
				B. Safety Glasses	<input type="checkbox"/>	<input type="checkbox"/>	
				C. Goggles	<input type="checkbox"/>	<input type="checkbox"/>	
				D. Face Shield	<input type="checkbox"/>	<input type="checkbox"/>	
				E. Hearing Protection	<input type="checkbox"/>	<input type="checkbox"/>	
				F. Respirator	<input type="checkbox"/>	<input type="checkbox"/>	
				G. Clothing	<input type="checkbox"/>	<input type="checkbox"/>	
				Type:			
				H. Gloves	<input type="checkbox"/>	<input type="checkbox"/>	
				I. Foot Protection	<input type="checkbox"/>	<input type="checkbox"/>	
J. Other (Description)							

17. How did the incident/accident occur? (Describe in detail the events that led to the incident/accident.)	
18. Describe any hazardous conditions, items or practices which contributed to the incident/accident.	
19. Names and phone numbers of witnesses	
20. How could this incident/accident have been prevented?	
21. Describe the specific actions to be taken to prevent a recurrence.	
_____ Immediate Supervisor (PRINT & SIGN)	_____ Date
22. This report has been reviewed with me.	
_____ Employee's Signature	_____ Date
_____ Department/Division Safety Representative (PRINT & SIGN)	_____ Date
Remarks by Division Head	
_____ Division Head (PRINT & SIGN)	_____ Date
Remarks by Department Head	
_____ Department Head (PRINT & SIGN)	_____ Date

- Distribution:
1. Copy to Health & Safety Division within 3 work days after incident/accident.
 2. Copy to Workers' Compensation Division within 5 days if medical treatment rendered along with a completed original WC-1 form.
 3. Original retained by Department (for permanent retention).

County of Hawai'i
Hawaii Fire Department
ELECTION OF COMPENSATION FOR INDUSTRIAL INJURY OR ILLNESS

Employee's Name	Department/Division/Station/Section	Date of Injury/Illness
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I understand that workers' compensation payments will be made in accordance with Section 386-31(b), Hawai'i Revised Statutes, from date of disability to day disability ends. I elect to receive workers' compensation wage replacement benefits according to the following options (please select all 9 options from any of the boxes below by numbering the boxes to indicate your 1st, 2nd and 3rd choice and so on). If you elect an option not available to you, the next option(s) you selected will be applied, as appropriate. ALL 9 BOXES NEED TO BE SELECTED IN ORDER OF PREFERENCE.

	Workers' compensation only. Workers' compensation benefits are calculated at 2/3 of your average weekly wage, subject to a maximum benefit established on January 1 st of each year. These payments are not taxable for federal and state income taxes.
	Workers' compensation plus sick leave to make up the difference between my regular pay and workers' compensation. This option allows you to use partial sick leave to add to your workers' compensation benefits, which are 2/3 of your average weekly wage. The sick leave portion is taxable, but the workers' compensation portion is not taxable. Most injured county employees select this option.
	Workers' compensation plus vacation to make up the difference between my regular pay and workers' compensation. This option allows you to use partial vacation to add to your workers' compensation benefits, which are 2/3 of your average weekly wage. The vacation portion is taxable, but the workers' compensation portion is not taxable.
	Workers' compensation plus compensatory time off (CTO) to make up the difference between my regular pay and workers' compensation. This option allows you to use partial CTO to add to your workers' compensation benefits, which are 2/3 of your average weekly wage. The CTO portion is taxable, but the workers' compensation portion is not taxable.

The following options are limited to employees eligible under Act 64 (*hazardous duty) or where provided for under union contract.

	100% of my regular pay for the first 120 calendar days of disability. This option allows you to receive your regular pay each payday as if you had no lost time from work. The amount is fully taxable. At the conclusion of the first 120 days of disability, you may elect any of the options above or any of the options below. Few employees select from the options below because regular workers' compensation will pay you 2/3 of your average weekly wage and is tax-free.
	60% of my regular pay. After the completion of 120 days where you received your full pay, this option allows you to receive 60% of your salary. This amount is fully taxable.
	60% of my regular pay plus 40% sick leave. After the completion of 120 days where you received your full pay, this option allows you to receive 60% of your salary plus enough sick leave to equal your full salary. The total amount is taxable.
	60% of my regular pay plus 40% vacation. After the completion of 120 days where you received your full pay, this option allows you to receive 60% of your salary plus enough vacation to equal your full salary. The total amount is taxable.
	60% of my regular pay plus 40% compensatory time off (CTO). After the completion of 120 days where you received your full pay, this option allows you to receive 60% of your salary plus enough CTO to equal your full salary. The total amount is taxable.

If you have any questions concerning this form, you may call Ms. Jean Viernes or Ms. Laura Casey in the Human Resources Section.

Employee's signature	Date:
Fire Chief or designee signature	Date

*Option applicable only to employees covered under HRS Chapter 78-24 (Hazardous Employment)

Original: Department Fiscal Officer
 cc: Department Work Comp File
 Employee
 County Workers' Compensation Branch/Third Party Administrator (TPA) as applicable