

<b>CITY OF ALGONA</b>		<b>Worker's Compensation</b>
<b>POLICY</b>		
<b>INDEX</b> HEALTH & SAFETY 415	<b>EFFECTIVE DATE</b> May 1, 2005	<b>APPROVED</b> CAB 35-05

**REFERENCE**

*RCW Title 51 – Industrial Insurance*

**PURPOSE**

To provide for an employee leave buy back program for employee's receiving time-loss payments from Washington State Department of Labor & Industries.

**POLICY**

All employees are insured by the Washington State Department of Labor & Industries Worker's Compensation program to protect them against medical costs from on-the-job accidents and injuries and for work time lost as a result of such accidents or injuries.

All accidents and on-the-job injuries must be reported to a supervisor. The supervisor shall direct the injured employee to seek immediate medical treatment if necessary, and shall be responsible for completing the "Supervisor's Report of Accident" form as well as ensuring , as soon as physically possible, that the injured employee completes the "Accident Report" form and submits both forms to the City Clerk's office.

Unless otherwise required by State law, the procedure for worker's compensation time loss payment/reimbursement will be as follows:

If the job-related injury or illness requires the employee to be absent from work, the time the employer is unable to work will be charged to sick leave. If the employee's sick leave has been exhausted, compensatory time or accrued vacation leave shall be used.

If the job-related injury or illness requires the employee to be absent from work for more than three (3) consecutive days, State Industrial Insurance (Worker's compensation) will begin to pay time loss compensation according to a set formula based on marital status and number of dependents. Employees cannot use sick leave and receive Worker's Compensation payments at the same time as this results in a double payment.

The City shall compensate the employee for the difference between his/her Worker's Compensation entitlement and his/her regular salary for a period not to exceed six (6) months or the termination of the disability, whichever comes first. To accomplish this, the City shall pay the employee his/her regular salary for said period and the employee shall receipt to the City all time loss payments received from Worker's Compensation Employee's shall not cash any time-loss checks, all checks must be endorsed to the City and turned into the Administration department promptly to cover reimbursement of advanced wages.

Upon receipt of the time-loss check, the City shall reinstate accumulated leave used at 100% for the period covered by said time loss as reported by the Department of Labor & Industries.

An employee receiving worker's compensation benefits continues to accrue vacation and sick leave. The City also continues to pay for the employer's portion of health insurance premiums, provided that the employee continues to pay their share of premiums for a period not to exceed six (6) months. Family medical leave benefits will run concurrently with L & I absences.

The City will be under no obligation to continue the employee's regular salary upon notice by the City to the employee of their failure to receipt time loss payments. Thereafter, the City will only compensate the employee for the difference between Worker's Compensation entitlement and his/her regular salary until the employee complies with this section.

An employee who has been away from work due to an injury many not return to work without a written statement from the appropriate medical personnel stating the employee is able to resume his or her job duties, or specifying limits on duties which can be performed.

## ATTACHMENTS

Accident Report Form  
Supervisor's Report of Accident

CITY OF ALGONA  
 402 Warde Street  
 Algona, WA 98001

**SUPERVISOR'S REPORT  
 OF AN ACCIDENT**

Name of injured Employee: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Length of employment: \_\_\_\_\_/yrs \_\_\_\_\_/mos Dept: \_\_\_\_\_

**INJURY DETAIL**

<input type="checkbox"/> Head <input type="checkbox"/> Eyes <input type="checkbox"/> Trunk <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Legs <input type="checkbox"/> Toes <input type="checkbox"/> Internal Remarks: _____ _____ _____	<input type="checkbox"/> burns <input type="checkbox"/> wounds <input type="checkbox"/> hernia <input type="checkbox"/> fracture <input type="checkbox"/> amputation <input type="checkbox"/> strain/sprain <input type="checkbox"/> foreign body <input type="checkbox"/> skin (occupational) Remarks: _____ _____ _____	<input type="checkbox"/> Death <input type="checkbox"/> Lost Time <input type="checkbox"/> First Aid Only  <input type="checkbox"/> due to delayed medical treatment. Remarks _____ _____
Date of Injury: _____	Time: _____	Location: _____
Witnesses: _____		

**Describe accident; include any machinery, equipment, object or substance involved:**


**CAUSE:**      Mark basic cause                       Mark contributing cause(s), if any

**UNSAFE CONDITIONS**

- inadequately guarded
- unguarded
- defective tools, equipment, or substance
- unsafe design or construction
- hazardous arrangement
- unsafe illumination
- unsafe ventilation
- unsafe clothing
- insufficient instruction

**UNSAFE ACTS**

- operating without authority
- operating at unsafe speed
- making safety devices inoperative
- using unsafe equipment or equipment safely
- unsafe loading, placing, mixing
- taking unsafe position
- working on moving or dangerous equipment
- distraction, teasing, horseplay
- failure to use personal protective devices

Why was unsafe act committed?
Why did unsafe condition exist?

**GUIDES TO CORRECTIVE ACTION**

*Based on the cause checked above, I am taking the following corrective action:*

**UNSAFE ACT**

**UNSAFE CONDITION**

**REFER TO:  
(if supervisor unable to handle)**

- Stop the worker
- Study the job
- instruct employee
- follow up

- Remove
- Guard
- warn
- supervisory training

- Supervisor
- safety committee
- maintenance dept, or

What I am doing to prevent similar injuries:

Describe any near accidents you have observed in the past:

Report any unsafe procedures you have observed in the past week (physical hazards are classed as unsafe procedures as well as human acts.)

**SIGNATURES**

\_\_\_\_\_  
Immediate Supervisor

\_\_\_\_\_  
Mayor

CITY OF ALGONA  
402 Warde Street  
Algona, WA 98001

### ACCIDENT REPORT FORM



#### INJURED EMPLOYEE

Name:	Social Security #:
Home Address:	
Age:	Male _____ Female _____
Job Title:	Department:

#### ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS

Address of accident/exposure:	
Was place of accident/exposure on employer's premises?	Yes _____ No _____
What was employee doing when injured?	
How did the accident occur?	
Witnesses:	

#### OCCUPATIONAL INJURY OR OCCUPATIONAL ILLNESS

Describe the injury or illness in detail and indicate the part of body affected:	
Date of injury or initial diagnosis of occupational illness:	Did employee die? Yes _____ No _____

#### OTHER

Name & Address of physician:		
If hospitalized, name and address of hospital:		
Date of Report:	Prepared by:	Official Title: