INCIDENT REPORTING PACKET
City of Hendersonville, NC

This packet includes all forms required in case of an incident resulting in personal injury, damage to a vehicle or equipment, or damage to property, such as a sign, mailbox, tree, etc.

When in doubt, complete the forms. The incident may not turn out to be a big deal but it's better to document an incident at the time than to try and recall details later. Forms should be completed before memory fades, 24-48 hours maximum. Attaching photos is a good idea.

This packet included the following forms.

- **Form 19.** To be completed by a supervisor, department head or administrative assistant in the case of personal/bodily injury.
- **Form 18.** To be completed by the employee if he/she believes a personal injury was not handled correctly by the City.
- **Employee's Report of Incident.** To be completed by the employee for all incidents (personal injury, damage to vehicle/equipment & damage to property).
- **Supervisor's Report of Incident.** Completed by supervisor/crew chief with department head signature.
- **Incident Witness Statement**. Completed by any employee or citizen who witnessed the incident.

All completed forms are to be returned to Human Resources with the department keeping copies for reference. The City of Hendersonville has retained the North Carolina League of Municipalities as our independent claim adjusting firm to handle claims for injured employees.

If because of medical issues an employee is unable to complete the Employees' Report of Incident at the time, use common sense and good judgment. Our employee's health and care are first and foremost. The form may be completed at a more appropriate time when the employee is physically able to document theaccident.

If an employee refuses to complete the form, you cannot make them. However, stress the importance of getting their account of the incident. Regardless, the Supervisor's Report and any Witness Statements should be completed.

There will be a follow up on all incidents by the HR Coordinator. This is to gain further background of the event and, hopefully, come up with ways to avoid any repeat.

North Carolina Industrial Commission

IC File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

***Emp. Code #**_____

***Carrier Code #**_____

Employer FEIN_____

Carrier File #_____

***Required Information.**

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The use of this form is required under the provisions of the Workers' Compensation Act

			City of Hendersonville		(828) 697-3000
Employee's Name			Employer's Name		Telephone Number
			160 6 Ave E,	Hendersonville	NC 28792
Address			Employer's Address	City	State Zip
			NCIRMA_WC	Worker's Comp	
City	State	Zip	Insurance Carrier	Policy Number	
			308 West Jordan St	Raleigh NC	27603
Home Telephone	Work Telephone		Carrier's Address	City	State Zip
	☐ M ☐ F		(888) 561-1083	(919) 715-8465	
Social Security Number	Sex	Date of Birth	Carrier's Telephone Number	Fax Number	

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County **Henderson** Department State if employer's premises
	3.	Date of injury 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began ☐ A.M. ☐ P.M.
	7.	Date you or the supervisor first knew of injury 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Time employed by you (b) Wages per hour **$**
	11.	(a) No. hours worked per day (b) Wages per day **$** (c) No. of days worked per week (d) Avg. weekly wages w/ overtime **$** (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. **$** per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work at : .M. 15. If so, at what wages **$** per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29)

Employer name _____ Date Completed _____

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.	
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No	Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Employer FEIN_____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name

Address

City State Zip

( ) -
Home Telephone

- - ☐ M ☐ F / /
Social Security Number Sex Date of Birth

Employer's Name ( ) -
Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ____/__/____ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

_____ ( ) -
Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent Telephone Number

Address City State Zip / /
Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FORM 18
8/6/08
PAGE 1 OF 1

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other three spaces, "Emp. Code No.," "Carrier Code No.," and "Employer FEIN" are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

Employee's Report of Incident

Employee's Name:		Department:	Supervisor:
Job Title:		Time with City:	Type of Incident: ☐ Injury ☐ Vehicle/Equipment ☐ Property
Date of Accident:	Time of Accident: ☐ AM ☐ PM	Date reported to supervisor:	Time reported to supervisor: ☐ AM ☐ PM
Location of Incident:		Number of vehicle/equipment	
Describe injury or damage:			
Describe fully how the incident occurred (including events that occurred immediately before the accident):			
Cause of incident:			
Recommendations for preventing this happening again:			
Was law enforcement involved? ☐ Yes ☐ No		Were photos taken? ☐ Yes ☐ No	
Did you have medical treatment? ☐ Yes ☐ No		Treatment facility name:	
Name(s) of witness(es):			
Employee's Signature:		**Date:**	

By signing I am stating the statement above is my own and true.

Supervisor's Report of Incident

(To be completed by the employee's supervisor or other responsible administrative official.)

Your name:	Employee involved:
Date of Incident:	Type of Incident: ☐ Injury ☐ Vehicle/Equipment ☐ Property
Describe injury or damage:	
What do you feel is the main cause of this incident?	
Could this have been prevented? ☐ Yes ☐ No	What can be done in the future to prevent this happening again?
Was PPE/safety equipment being used? ☐ Yes ☐ No	Note safety equipment/PPE in use at time of incident:
Was law enforcement involved? ☐ Yes ☐ No	Were photos taken? ☐ Yes ☐ No
Do you plan disciplinary action ☐ Yes ☐ No	If yes, what?
Further comments:	
Supervisor's Signature	**Date:**
Department Head's Signature:	**Date:**

Incident Witness Statement

Name of Witness:		City Employee? ☐ Yes ☐ No
If not employeed by City, witness contact information		
Witness address:	City, State:	Zip:
Witness phone:	May we or our insurance company contact you directly if we have further questions? ☐ Yes ☐ No	
Observations		
Location of incident:		
Fully describe what you observed concerning the incident including events prior:		
What do you fee is the main cause of the incident?		
Recommendation on how to prevent this from recurring?		
Witness's Signature:	**Date:**	