Incident Report

Type of Incident – *Check all that apply*

☐ Staff ☐ Client	☐ Other *(Please describe)*	File Insurance Claim	☐ Yes ☐ No
☐ HIPAA/Security Breach Date of Discovery: _____	☐ Facilities Incident *(i.e. property damage, theft)*	☐ Vehicular Accident	
☐ Biohazard Accident	☐ Injury - ☐ Staff ☐ Client	☐ Undue Influence	
☐ Communicable Disease	☐ Infection Control	☐ Issue of Non-compliance	
☐ Violence or Aggression	☐ Use or Possession of Weapon	☐ Physical Assault	
☐ Sexual Assault	☐ Suicide or Attempted Suicide	☐ Adverse Medication Reaction	
☐ Medication Error Requiring Medical Intervention	☐ Use or Possession of Illegal Substance	☐ Sentinel Event (Death of client)	
☐ Elopement or Wandering	☐ Missing Person	☐ Fall	
☐ Abandonment	☐ Abuse	☐ Exploitation	
☐ Neglect	☐ Worker's Comp Claim – *(f checked complete worker's comp for)*		
☐ Self-Neglect	Event attacked by dog delivering meal		

Information about the Incident - *Click the box that best describes the division and program associated with the incident*

CCS Division	☐EO	☐ CFS	☐HHCJ	☐SESS	
				Location	Program
CCS Program Location	☐ Main Office ☐ Other location	☐ Main Office ☐ CAC ☐ CCAP ☐ Other location	☐ Main Office ☐ Hospice ☐ Home Health ☐ Other location	☐ Angoon ☐ Craig/Klawock ☐ Haines ☐ Hoonah ☐ Juneau ☐ Kake ☐ Ketchikan/Saxman ☐ Skagway ☐ Sitka ☐ Wrangell ☐ Yakutat	☐ Senior & Care Giver Counseling ☐ Senior & Care Giver Resources ☐ Case Management ☐ Senior Center ☐ CAV/Transportation ☐ Bridge ☐ Meals on Wheels ☐ Other _____

This section MUST be completed

Date of Incident	Time of Incident	Location of Incident	Name(s) of CCS Staff Involved
		Angelina Stockton residence	

Name(s) of Others Involved	Contact Information for Others Involved

Name(s) of Witnesses *(if applicable)*	Contact Information for Others Involved

Police Notified?	Name of Officer	Date of Call	Time of Call	Phone #	Case #
☐ Yes ☐ No			☐ AM ☐ PM		

Doctor / Paramedic Contacted?	Name of Doctor/Medic	Date of Call	Time of Call	Phone #
☐ Yes ☐ No			☐ AM ☐ PM	

VEHICULAR ACCIDENT INFORMATION *(only complete if applicable)*

☐ COMPLETE POST ACCIDENT DECISION TREE	Was Daily Bus Driver's (pre-trip) Inspection Report Completed?	☐ Yes ☐ No
Describe the Weather Conditions At Time of Accident		
Safety Belts Used?	Driver: ☐ Yes ☐ No	Passengers: ☐ Yes ☐ No

CCS Vehicle Involved	**Make**	**Model**	**Year**	**License Plate #/ State**	**Vin #**	**Driver's Name**	**Driver's Injuries**
							☐ Yes ☐ No *If yes describe in narrative section*
Other Vehicle Involved	**Make**	**Model**	**Year**	**License Plate #/ State**		**Driver's Name**	**Driver's Injuries**
							☐ Yes ☐ No *If yes describe in narrative section*
	Driver's Address *(include City, State, and Zip)*			**Phone #**		**Insurance Provider**	**Policy #**

Other Persons *(passenger & pedestrian)*	**Name**	**Address** *(include city, state, & zip)*	**Phone #**	**Other Person Injury**
				☐ Yes ☐ No *If yes describe in narrative section*

Witness to Vehicular Accident	**Name**	**Address** *(include City, State & Zip)*	**Phone #**

Accident Photos	☐ Yes ☐ No ***Please submit pictures of damage to vehicles involved in accident via email**

Preventable Accident – Click a choice below		**Non-Preventable Accident - Click a choice below**
☐ Backing	☐ Speed too fast for conditions	☐ Hit by another car
☐ Turning	☐ Failure to signal intentions	☐ Hit while legally parked
☐ Parking	☐ Disregard of traffic signals	☐ Hit in rear
☐ Passing	☐ Assuming right of way	☐ Struck by debris
☐ Following Distance	☐ Driving in wrong lane	☐ Vandalism
☐ Diverted Attention	☐ Starting and stopping	☐ Windshield
☐ Misjudged Clearance	☐ Failure to Maintain Vehicle	☐ Stolen while locked
☐ Driving under influence of drugs and/or alcohol		☐ Fire
		☐ While being towed by tow truck
☐ Other – *please describe*		☐ Other – *please describe*

INCIDENT DESCRIPTION – MUST BE COMPLETED
Describe the Incident in <u>DETAIL</u> including: what happened, where it happened, who was involved, how it happened, factors leading up to the event, substances or objects involved ***(be as specific as possible):***
If there was an injury or illness, describe the injury or symptoms of illness (laceration, sprain, etc.) including the part of the body injured, and any other known information about the resulting injury*(be as specific as possible):*:

If injury, was individual transported to medical facility	☐ Yes ☐ No	**Who transported**	

Reporter Printed Name and Title			
Reporter Signature		**Date**	

Reporter: Please send completed report to supervisor for review within <u>12 hours of the following business day of incident</u>

SUPERVISOR FOLLOW-UP – MUST BE COMPLETED BY SUPERVISOR
What act, failure to act and/or conditions contributed most directly to this incident? ***(please describe in detail)***

What action(s) have you taken or recommended to prevent a reoccurrence? ***(please describe in detail)***

Was there loss of income due to accident/incident?	☐ **Yes** ☐ **No**	**Amount?**	
Should a claim be filed with insurance?	☐ **Yes** ☐ **No**		

Supervisor/Reviewer Information

Print Name and Title			
Supervisor Signature		**Date**	
Completed SDS "SDS Critical Incident Report"?	☐ **Yes** ☐ **No**		

Routing: Within 12 hours of the receipt of the report send to: ☐ Compliance Officer ☐ Human Resources

Attachments: ☐ Photos ☐ Police Report **(***if available***)**

COMPLIANCE OFFICER REVIEW			
Claim filed with insurance?	☐ Yes ☐ No	**Additional follow-up required?**	☐ Yes ☐ No
Additional Comments:			
Compliance Officer Printed Name:			
Compliance Officer Signature:		**Date:**	
HUMAN RESOURCES REVIEW			
Claim filed with worker's comp?	☐ Yes ☐ No	**Additional follow-up required?**	☐ Yes ☐ No
Was Post Accident Decision Tree Followed?	☐ Yes ☐ No	**Additional follow-up required?**	☐ Yes ☐ No
Additional Comments:			
HR Staff Printed Name:			
HR Staff Signature:		**Date:**	

POST ACCIDENT TESTING DECISION REPORT

A separate sheet must be filled out for each covered employee that contributed to the accident

System Name: _____ Date of Accident: _____

Time of Accident: _____ Time Employer was notified: _____

Location of Accident: _____

Safety-Sensitive Employee: _____ ID # and Position:_____
i.e. Driver, Dispatcher, etc.

1. Did the accident involve a public transit vehicle?		☐ Yes	☐ No
2. Did the accident involve the operation of the vehicle?		☐ Yes	☐ No
3. Was there loss of life as a result of the accident?*		☐ Yes	☐ No
4. Did an individual suffer a bodily injury and immediately receive medical treatment away from the scene?*		☐ Yes	☐ No
5. Was there disabling damage to any of the involved vehicles?*		☐ Yes	☐ No
6. a) Did you perform a drug and/or alcohol test? ***(Use Decision Tree on this form)***	☐ Yes *(DOT-FTA Authority)*	☐ Yes *(NON-DOT Company Authority)*	☐ No
b) If no, why not?			
c) For a non-fatal accident, can the covered employee(s) performance be completely discounted as a contributing factor to the accident?		☐ Yes	☐ No
7. a) Was an alcohol test performed within 2 hours?	☐ NA	☐ Yes	☐ No
8. If no alcohol test occurred, and more than 8 hours elapsed from the time of the accident, please explain:			
9. a) Was a drug test performed within 32 hours?	☐ NA	☐ Yes	☐ No
b) If no, why:			
10. a) Did the employee leave the scene of the accident without a reasonable explanation?		☐ Yes	☐ No
b) If Yes, please explain:			

Test Determination:

Name of supervisor making determination: _____

Time employee was informed of determination: _____

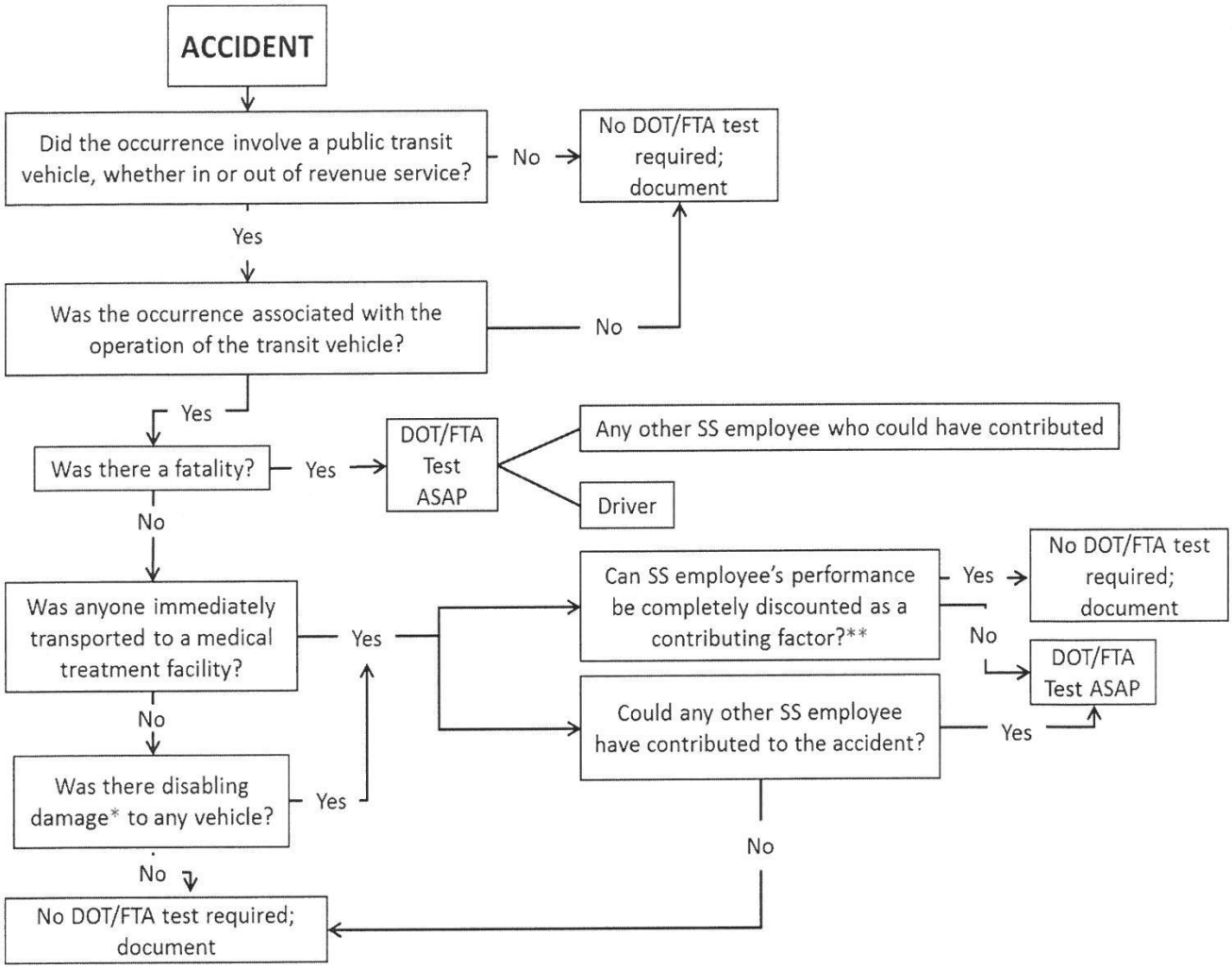
_____ _____
Signature & Title Date

*Disabling Damage: Damage that precludes departure of a motor vehicle from the scene of the accident in its usual manner in daylight after simple repairs.

1. Inclusion: Damage to a motor vehicle, where the vehicle could have been driven, but would have been further damage if so driven.
2. Exclusions:
   a. Damage that can be remedied temporarily at the scene of the accident without special tools or parts.
   b. Tire replacement without other damageeven if no spare tire is available.
   c. Headlamp or tail light damage.
   d. Damge to turn signals, horn, or windshield wiper, which makes the vehicle inoperable.

** Contributing Factor: The determination of whether or not a safety-sensitive employee's performance was a contributing factor should be the decision of the company official investigating the accident; not baed on the police officer's accident fault determination. This decision must be based on the best available information at the time of the accident.

Post Accident Decision Tree



---

* **Disabling Damage:** Damage that precludes departure of a motor vehicle from the scene of the accident in its usual manner in daylight after simple repairs.

(1) Inclusion: Damage to a motor vehicle, where the vehicle could have been driven, but would have been further damaged if so driven.

(2) Exclusions:

A. Damage that can be remedied temporarily at the scene of the accident without special tools or parts.

B. Tire replacement without other damage even if no spare tire is available.

C. Headlamp or tail light damage.

D. Damage to turn signals, horn, or windshield wiper, which makes the vehicle inoperable.

** **Contributing Factor:** The determination of whether or not a safety-sensitive employee's performance was a contributing factor should be the decision of the company official investigating the accident; not based on the police officer's accident fault determination. This decision should not be made hastily. The company official's determination must be based on the best available information at the time of the accident.