



City of Jackson Risk Management

EIR & AIR Form Completion Policy

Complete a EMPLOYEE INJURY REPORT (EIR)

- Any time a city employee is injured

An EIR will need to be completed, signed by the injured employee, the injured employee's supervisor and sent to Risk Management within 24 hours. A fax will suffice until the original can be delivered.

Complete an ACCIDENT-INCIDENT REPORT (AIR)

If an employee is:

- involved in an auto accident while in a city owned vehicle
- involved in an auto accident while in personal vehicle but doing city business
- involved in or witnesses any kind of incident on city property
(*example: Citizen falls while entering your office*)
- involved in or witnesses any incident possibly caused by city property or city employee
(*example: City mower throws rock, hits passing vehicle*)
- receives notice from a citizen that an incident has occurred involving a city employee or city property
(*example: citizen calls & says they fell at The Ned while there over the weekend attending a show*)
- witnesses or discovers any kind of damage to or theft of city property

An AIR will need to be completed, signed by the person(s) involved and sent to Risk Management within 24 hours. A fax will suffice until the original can be delivered.

IF IT IS AN AUTO ACCIDENT:

The police will need to be called immediately, even if there is no damage. The City's insurance carrier requires a police report. If the city employee is injured in the incident, the EIR will need to be completed as well, so in this case two reports will need to be completed (AIR & EIR) and sent to Risk Management. The City of Jackson does not have physical damage coverage on its vehicles; therefore, the department will have to pay to have a damaged city vehicle repaired. If another party was involved in the accident & they were at fault, the Risk Management department will contact them or their insurance company for subrogation.

IF THERE IS A THEFT OR VANDALISM OF CITY PROPERTY:

The police need to be called to investigate. An AIR should be completed at time of occurrence describing property damaged or stolen including the value. Once Risk Management receives this information we make a decision whether an insurance claim is to be filed or if the department is to absorb the cost. We currently have a \$2500 deductible and our property coverage pays replacement cost, however depreciation is a factor. Standard operating procedure is that it is reported to our office upon discovery. We have a timely filing requirement of 30 days.

THIS FORM MUST
BE COMPLETED
WITHIN 24 HOURS
OF INJURY/ILLNESS
PLEASE COMPLETE ALL SECTIONS

CITY OF JACKSON
EMPLOYEE INJURY REPORT (EIR)

RISK MANAGEMENT
SHOULD BE NOTIFIED
IMMEDIATELY OF
ANY SERIOUS
INJURY/ILLNESS

***This form must be completed if an employee is injured while on duty. Complete OJI Policy is available on City intranet.
* This form must be given or faxed to the Risk Management Office within 24 hours of the injury. 425-8606**

DATE OF INJURY:		TIME OF OCCURRENCE:		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		BEFORE/DURING/AFTER SHIFT?	
FULL NAME:		SS#:		BIRTHDATE:		AGE:	GENDER:
STREET ADDRESS:		CITY/STATE/ZIP:				RACE:	
HOME/CELL PHONE:		DEPT:		JOB TITLE:			
HIRE DATE:		FULL <input type="checkbox"/> PART <input type="checkbox"/>	EMP#:	STREET LOCATION OF OCCURRENCE:			

WHAT WERE YOU DOING IMMEDIATELY PRIOR TO INJURY?

PROVIDE DETAILED DESCRIPTION OF HOW THE INJURY OCCURRED & HOW IT IS DIRECTLY RELATED TO YOUR JOB: (use back of page if needed)

DESCRIBE INJURY/ILLNESS AND BODY PART AFFECTED: (Example: minor cut to left upper arm)

WHAT OBJECT OR SUBSTANCE, IF ANY, DIRECTLY HARMED EMPLOYEE?

WAS ANY TYPE OF PERSONAL PROTECTIVE EQUIPMENT BEING WORN AT TIME OF INJURY? YES NO If so, what?

WAS FIRST AID ADMINISTERED? YES NO BY WHOM?

DESCRIBE TREATMENT:

WAS OUTSIDE MEDICAL TREATMENT REQUIRED? YES NO FACILITY NAME:

WILL LEAVE TIME BE REQUIRED? YES NO (A MEDICAL STATEMENT IS REQUIRED FOR PAID TIME.)

DATES NOT REPORTING TO WORK PER THE PHYSICIAN'S STATEMENT:

LIST ANY WITNESS TO THE INJURY/ILLNESS:

PLEASE LIST ANY CURRENT EMPLOYERS, OTHER THAN THE CITY OF JACKSON:

DO YOU HAVE ANY SUGGESTIONS TO KEEP THIS FROM HAPPENING TO SOMEONE ELSE?

As a City of Jackson employee, by signing this form below, I hereby certify that the information above is complete & true and I give consent to the City of Jackson and/or my case manager to discuss my injury, noted above, with my treating physician. I have also been informed by my supervisor of where I may find a copy of the OJI Policy.



SIGNATURE INJURED EMPLOYEE

DATE

Employee was given a copy of or informed of where a copy of the OJI Policy can be obtained.

SIGNATURE IMMEDIATE SUPERVISOR

DATE

REVIEWED BY:	To be completed by the reporting dept.	
	OJI Contact for this Dept: (print): _____	
DEPARTMENT HEAD SIGNATURE	DATE	OJI Contact's email: _____
Date Received by RM: _____		OJI Contact's Phn#: _____
Date Sent to BWS: _____		

Please complete an accident/incident report if City property was damaged when injury occurred or a citizen is somehow involved.

**CITY OF JACKSON
ACCIDENT/INCIDENT REPORT (AIR)**

***This form must be completed when City property is damaged or a citizen reports an incident or injury related to the GOJ.
*This form must be filed with Risk Management within 24 hours of occurrence.**

DATE OF INCIDENT:	TIME:	LOCATION:	CITY DEPARTMENT INVOLVED:
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PLEASE PROVIDE A DETAILED EXPLANATION WHAT HAPPENED?

SECTION 1 (COMPLETE IF CITY PROPERTY IS DAMAGED OR IF CITIZEN PROPERTY IS DAMAGED BY A CITY EMPLOYEE)

DAMAGED PROPERTY IS OWNED BY: <input type="checkbox"/> CITY <input type="checkbox"/> CITIZEN <input type="checkbox"/> BOTH	WERE POLICE CALLED? Yes <input type="checkbox"/> No <input type="checkbox"/>	POLICE REPORT#:
WERE PHOTOS MADE? Yes <input type="checkbox"/> No <input type="checkbox"/>	WHERE CAN PHOTOS BE SEEN?	

CITY INFO


NAME OF EMPLOYEE(S) INVOLVED:	DESCRIBE THE CITY PROPERTY THAT WAS DAMAGED:
IF MVA, DRUG SCREEN IS REQUIRED- WHERE WAS DRUG SCREEN DONE?	WAS EMPLOYEE INJURED? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete EIR form also

CITIZEN INFO

NAME/ADDRESS/PHONE# OF CITIZEN INVOLVED:	
DESCRIBE THE PROPERTY THAT WAS DAMAGED:	OWNER OF PROPERTY (if different from citizen involved):
INSURANCE INFO OF CITIZEN:	WAS CITIZEN INJURED? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete section 2
WITNESSES TO ACCIDENT/INCIDENT (name,address,phone)	

SECTION 2 (COMPLETE IF INJURY TO CITIZEN OCCURRED ON CITY PROPERTY OR DUE TO PROPERTY DAMAGE ABOVE)

FULL NAME OF PERSON INJURED:	DATE OF BIRTH:	
ADDRESS:	PHONE#s	
WAS INJURED PERSON A PROGRAM PARTICIPANT? Yes <input type="checkbox"/> No <input type="checkbox"/>	PROGRAM NAME:	
IF MINOR, PARENT/GUARDIAN NAME:	PHONE#:	CONTACTED? Yes <input type="checkbox"/> No <input type="checkbox"/>
DESCRIBE INJURY AND BODY PART AFFECTED: (Example: minor cut to left upper arm)		
WAS FIRST AID ADMINISTERED? Yes <input type="checkbox"/> No <input type="checkbox"/>	BY WHOM?	
WAS OUTSIDE MEDICAL TREATMENT REQUIRED? Yes <input type="checkbox"/> No <input type="checkbox"/>	FACILITY/MD WHERE TREATMENT WAS RENDERED:	
DID ANY OBJECT CONTRIBUTE TO THIS INJURY? Yes <input type="checkbox"/> No <input type="checkbox"/>	IF YES, WAS INSPECTION MADE & BY WHOM?	
FINDINGS OF INSPECTION?		
WERE PHOTOS TAKEN OF AREA WHERE INJURY OCCURRED? Yes <input type="checkbox"/> No <input type="checkbox"/>		
LIST ANY WITNESS TO THE INJURY/ILLNESS: (name/address/phone)		

Signatures:		_____ (Employee/Citizen Involved)	_____ (Date)
_____ (Department Head)	_____ (Date)	_____ (Supervisor)	_____ (Date)

Please complete an employee injury report if a city employee was injured while on duty, due to the above accident/incident.