CAPITAL CITY FIRE/RESCUE **SOG NUMBER 45.0**

STANDARD OPERATING GUIDELINES **DATE: August 10, 2007**

REVISION DATES:

OCCUPATIONAL INJURIES

OBJECTIVE:

To provide guidance in the instance of an on-duty injury occurring to CCF/R personnel

GUIDELINE:

45.1 Obtain medical assistance as needed for CCF/R personnel injured on duty.

45.2 The Duty Officer must be advised of any injury requiring completion of a workman's compensation form or significant injury.

45.3 The Duty Officer will notify the Fire Chief, City Manager and Risk Management as soon as possible of on-duty, significant injuries or fatality of CCF/R personnel.

45.4 All on-duty injuries to CCF/R personnel must be documented immediately and turned into Administration within three days of the incident.

45.4.1 An Incident Report (Appendix A) must be completed by the supervisor.

45.4.2 A workman's compensation form must be completed for all significant injuries or for any injury or exposure if the employee so desires. The employee must complete items 1-17 of "Report of Occupational Injury or Illness (Alaska Department of Labor fore DOL-6101). If the member's medical status doesn't permit the completion of the form, note the reason on item #16 (i.e. hospitalization or unavailable for signature) These forms are available at each station and in the injury and exposure report packets on each ambulance.

The supervisor must complete the remainder of the form except item #37

The blue and white copies are to be transmitted to Risk Management. The pink copy will be placed in the employee's file

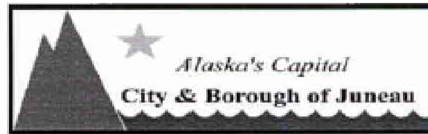
The yellow and green copies are given to the employee.

45.4.3 For minor injuries, if the employee desires, a minor injury report (Appendix B) may be completed instead of a workman's compensation report. Minor injury

reports will be retained in the employee's confidential health file for a period of one year or until the employee wishes to have the report removed.

45.5 Prior to returning to duty from an injury, the department member's physician must complete the Certification of Health Care Provider form (Appendix C), and the form must be returned to Administration.

INCIDENT REPORT



1. DEPARTMENT/DIVISION:	2. REPORT DATE:
3. INCIDENT DATE:	4. TIME: (AM/PM)
5. LOCATION OF INCIDENT: *(BE SPECIFIC)*	
6. INVOLVED OR REPORTING CBJ EMPLOYEE(S):	
7. SUPERVISOR:	
INJURY OR ILLNESS INVOLVING A CBJ EMPLOYEE:	
8. NAME:	
9. OCCUPATION:	
10. FIRST AID, MEDICAL TREATMENT, OVERNIGHT HOSPITALIZATION OR NONE INDICATED? (CIRCLE)	
11. NATURE OF ILLNESS OR INJURY: (DESCRIBE)	
DAMAGE OR LOSS OF CBJ PROPERTY:	
12. CBJ PROPERTY DAMAGE OR LOSS: (DESCRIBE)	
13. CBJ VEHICLE OR EQUIPMENT NUMBER:	14. $ ESTIMATE:
INJURY OR ILLNESS INVOLVING THE PUBLIC:	
15. NAME, ADDRESS AND PHONE:	
16. NATURE OF ILLNESS OR INJURY: (DESCRIBE)	
PROPERTY DAMAGE OR LOSS INVOLVING THE PUBLIC:	
17. CLAIMANT/PROPERTY OWNER: (NAME, ADDRESS, PHONE, DRIVER'S LICENSE NUMBER, INSURANCE INFORMATION ETC; AS NEEDED DEPENDING ON THE NATURE OF THE INCIDENT.)	
18. PROPERTY LOSS OR DAMAGE: (DESCRIBE)	
	19. $ ESTIMATE:

20. POLICE REPORT? *(YES OR NO)*	21. REPORT BY OTHER AGENCY OR DEPARTMENT? *(YES OR NO)*
22. PHOTOS? *(YES OR NO)*	23. TAKEN BY?

24. DEPARTMENT/DIVISION MANAGEMENT NOTIFIED? *(YES OR NO)*

25. CLAIMANT/PROPERTY OWNER GIVEN CBJ DEPARTMENT CONTACT CARD? *(YES OR NO)*

26. [illegible]

INCIDENT WITNESSES [illegible]

A.

B.

C.

INCIDENT INVESTIGATION

27. INCIDENT INVESTIGATED BY:	28. DATE:

29. CORRECTIVE ACTION TAKEN IN RESPONSE TO THE FINDINGS OF THE INVESTIGATION? *(YES OR NO)*

30. CORRECTIVE ACTION TAKEN: *(CIRCLE APPROPRIATE CATEGORY(IES) AND WRITE THE DATE EACH WAS COMPLETED IN THE SPACE PROVIDED.)*

A. VERBAL INSTRUCTION:	B. EQUIPMENT/FACILITY REPAIR:
C. TRAINING/EDUCATION:	D. CHANGE IN S.O.P. *(STANDARD OPERATING PROCEDURE)*

E. CHANGE OR PURCHASE OF PERSONAL PROTECTIVE EQUIPMENT?

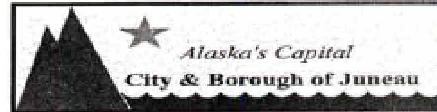
F. OTHER: *(PLEASE SPECIFY)*

31. ADDITIONAL INFORMATION: *(AS NEEDED)*

32. SUPERVISOR REVIEW: *(NAME)*	33. DATE:
34. SUPERVISOR TITLE:	
35. COPY OF THIS REPORT SENT TO RISK MANAGEMENT? *(YES OR NO)*	36. DATE:

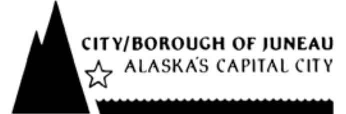
MINOR INJURY REPORT

Use to document minor injuries which you do not expect to require further medical attention.
Not for actual or potential exposures!



1. ASSIGNED STATION OR DISTRICT:	2. REPORT DATE:
3. INCIDENT DATE:	4. TIME: (AM/PM)
5. LOCATION OF INCIDENT: *(BE SPECIFIC)*	
INJURY OR ILLNESS INVOLVING A CCF/R MEMBER:	
8. NAME:	
7. SUPERVISOR:	
10. FIRST AID RENDERED, IF ANY:	
11. NATURE OF ILLNESS OR INJURY: (DESCRIBE)	
26. **WHAT HAPPENED?** (RECORD THE FACTS: DESCRIBE THE OPERATION, ACTIVITY, CONDITIONS AND HOW THE INJURY OCCURRED. INCLUDE A DIAGRAM IF NECESSARY.)	
Should medical attention become neccesary, notify your supervisor immediately & complete the CBJ Incident Report & Worker's Compensations forms.	

Top copy to CCFR Headquarters; yellow copy to injured employee



Certification of Health Care Provider

TO:

FROM: **Director**

RE: **Fitness for duty**

DATE:

Please sign the Certification of Health Care Provider and provide it, along with the copies of your position description, and the form attached and the stamped envelope, to your doctor. Please ask your doctor to fill out the Certification of Health Care Provider form and the form below and mail it back to (Director's name) in the enclosed envelope as soon as possible.

If you have any questions, please call me at .

Employee's Name: ______________________________ SSN:

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Employee Signature: ______________________________ Date:

Dear Health Care Provider:

_____________ is an employee at CBJ. Please assist us in determining the nature of his health needs and how we can best accommodate those needs by providing the following information and returning this completed form to us in the enclosed stamped, self-addressed envelope.

1. Does this employee have a physical impairment that substantially limits one of more of the major life activities, such as working or performing manual tasks?

2. Describe the medical facts which support your diagnosis:

3. What stimuli might cause this employee to have a reaction which could cause further harm or worsen the condition?

4. How long do you estimate that the employee will be physically unable to perform the normal functions of their position.

5. The essential functions of this employee's position include:

Searches area and rescues people from fires and other emergencies; carries children, injured, infirm or frightened people from burning buildings; locates and digs out people trapped in tunnels, pipes, excavations; rescues people trapped on cliffs, ledges, etc.; performs water or ice rescues; evacuates people from hazardous spills/areas of contamination by chemicals, gas, etc.

Responds quickly to alarms/pagers; puts on protective clothing rapidly and loads necessary equipment/ apparatus; selects best route to fire or emergency scene.

Operates, maintains and utilizes a wide variety of firefighting apparatus and equipment to effectively suppress fires.

Assesses properties of fire, such as smell and color of smoke, to determine what is burning and what equipment and extinguishing agents to use and what protective gear to wear; assesses effects of weather, wind, humidity and other conditions on the fire; assesses best route for evacuation and access to the fire scene; relays information to responding firefighters.

Listens, relays and follows the verbal orders of Fire Chief/incident commander at the scene.

Evaluates whether entry of burning structure is feasible; forces open doors, windows or gates; breaks or cuts into walls, roofs or fences to gain access to fire or to search area.

Checks, operates and maintains generators, air compressors, breathing apparatus, light plants, rescue equipment and other specialized firefighting/rescue equipment and tools; maintains records and prepares reports on equipment tests, usage and fire and ambulance incidents.

Operates ambulance and other related emergency equipment; assesses general condition of injured individual by noting vital signs, pupil dilation, respiration, skin temperature, alertness, mental orientation.

Administers necessary first aid and emergency care to stabilize the patient for transport; administers CPR; administers intravenous fluids and medications to patient on instruction from medical personnel; checks victims at scene for medic alert symbols or emblems;

transports patient to ambulance or emergency vehicle with special care to avoid further injury.

Knowledge, Skills and Abilities:

Knowledge of: the safe and effective operation, preventive maintenance and repair of a wide variety of fire department equipment, apparatus and tools; CPR and emergency medical techniques; local water systems, hydrant systems, road systems; operation of fire alarm system and station operations.

Skill in: rescue techniques, assessing fire scene for access and effect of wind or other variables; rendering emergency medical care, the safe and effective operation of fire department apparatus and equipment.

Ability to: safely and effectively commit and operate firefighting vehicles, apparatus and equipment; think clearly and quickly; analyze situations accurately and take prompt effective action during emergency situations; learn operating procedures; work cooperatively with others with their respect and confidence; function with a high degree of independence; keep simple records; prepare reports and follow oral and written directions.

A copy of the relevant job description and CBJ's ADA policy is attached. Can you suggest any accommodations we should consider?

________________________________ __________________ ____________

Signature of Health Care Provider   Type of Practice   Date

____

Address   Telephone Number