

**Town of Easton
Safety and Health Committee**

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CHRISTINE HALLORAN
TOWN CLERK
EASTON CT

**Minutes
April 25, 2014 Special Meeting
Library Conference Room**

Present: Bernadette Baldino, Suzette Bryan, Terry Calgreen, Vicki Cram, Althea Falco, and Gary Simone (by telephone conference call)

Matthew Lipp from CIRMA also attended as did First Selectman Adam Dunsby.

The meeting was called to order at 10:25 a.m.

The purpose of the special meeting was to review the accident reporting and investigation forms. Bernadette Baldino presented a draft revision to the Supervisor's Report of Accident Part A and Part B for the Committee's review. The new forms are:

1. CIRMA's claim reporting form – recommended to replace Supervisor's Report of Accident - Part A
2. CIRMA's accident investigation form – recommended to replace Supervisor's Report of Accident – Part B

Ms. Baldino stated the motivation to revise the forms was to cut down on repetition in completing the form information and to improve reporting both in time and content. The accident investigation form provides a list of possible factors that may have contributed to the injury or illness that will be helpful to the individual who completes the form.

The form will be two-sided. The second side which does not include personal employee information will be the one that is copied for review at future Safety and Health Committee meetings.

Motion:

Move to accept and approve the new Supervisor's Accident Reporting and Investigation forms designed and provided by CIRMA. The new forms will replace the current forms immediately.

Falco, Simone. Approved. Unanimous.

Copies of the new forms are attached to these minutes. Matt Lipp from CIRMA will prepare a letter that can be used to instruct all supervisors about the purpose of the new forms. Copies of the letter and the forms will be distributed as early as next week.

ADJOURNMENT

Motion: move to adjourn the meeting. Falco, Calgreen. Approved. Unanimous.

The meeting adjourned at 10:39 a.m.

Respectfully submitted by

Vicki Cram, Secretary

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EASTON TOWN CLERK ASST



CIRMAcare Injury Reporting Hotline

1-800-652-4762 (24 hours)

REVISED 9/21/08

LOSS INFORMATION

Loss Date: _____ Loss Time: _____ Call Type: Claim ☐ Occurrence ☐
Caller's First & Last Name: _____ Caller's Telephone Number: _____
Injured Employee's Employment Status: Full Time ☐ Part Time ☐ Volunteer ☐ Other ☐
Loss Location Name: _____
Loss Location Address: _____ City & State: _____ Zip Code: _____

INJURED EMPLOYEE'S INFORMATION

Employee's First & Last: _____
Employee's Home Address: _____ City & State: _____ Zip Code: _____
Employee's Social Security Number: _____
Employee's Telephone Numbers Work: _____ Home: _____
Gender: Male ☐ Female ☐ Date of Birth: _____ Job Title: _____
Department: _____
Supervisor's Name: _____ Telephone Number: _____
Employee's Hire Date: _____
Did employee miss work beyond normal shift? Yes ☐ No ☐ If yes, continue below
Last Day Worked: _____ Disability Date: _____ Returned to Work: _____
Time Employee Began Work: _____ Date Employer Notified: _____
Loss Description: _____
Injury Type: _____ Cause of Injury: _____ Body Parts Involved: _____
Contact Name: _____ Telephone Number: _____

TREATMENT INFORMATION (If known)

Name of Physician: _____ Physician's Telephone Number: _____
Name of Hospital: _____ Hospital Telephone Number: _____

WITNESS

Name: _____ Address: _____
City & State: _____ Zip Code: _____ Telephone Number: _____

CLAIM NUMBER: _____



Supervisor's Accident Review Form

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

Location where accident occurred		Employer's Premises: Yes <input type="checkbox"/> No <input type="checkbox"/> Job site: Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of accident or illness
Who was injured?		<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee		Time of accident a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred?	
What property/equipment was damaged?			Property/equipment owned by:	
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?				
How did injury/illness occur? List all objects and substances involved.				
Part of body affected/injured?				
Any prior physical conditions? If so, what? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Nature and extent of injury/illness and property damaged (be specific)				

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

- | | | |
|---|--|--|
| <input type="checkbox"/> Failure to lockout | <input type="checkbox"/> Improper maintenance | <input type="checkbox"/> Poor housekeeping |
| <input type="checkbox"/> Failure to secure | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Poor ventilation |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Inoperative safety device | <input type="checkbox"/> Unsafe arrangement or process |
| <input type="checkbox"/> Improper dress | <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Unsafe equipment |
| <input type="checkbox"/> Improper guarding | <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Unsafe position |
| <input type="checkbox"/> Improper instruction | <input type="checkbox"/> Physical or mental impairment | <input type="checkbox"/> Other _____ |

Supervisor's corrective action to ensure this type of accident does not recur: _____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? ... Yes ☐ No ☐

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? ... Yes ☐ No ☐

Did employee promptly report the injury/illness? ... Yes ☐ No ☐

Is there modified duty available? ... Yes ☐ No ☐

Supervisor's Name

Supervisor's Signature

Telephone Number

Date

CIRMA, 900 Chapel Street, 9th Floor, New Haven, CT 06510

ACCIDENT REVIEW FORMS | D5