S&E Report Employee Incident Report (Complete/email within 24 hours to rmclaims@horrycounty.org)

1. Immediately report incident or damage to your supervisor. Send completed report to Risk Management within 24 hours of incident.

A. TYPE OF INCIDENT - *CIRCLE ALL THAT APPLY*

☐1000 - Motor Vehicle Incident ☐1002 - Personal Injury/Illness ☐1003B - Non-County Employee Injury
☐ 1001 - County Vehicle Damages ☐1003A - Non-County Property Damage ☐1006 - Damage to other County Property

B. EMPLOYEE INFORMATION **Print Department Name: __**

Last Name	First Name	MI	Age
ID. #	Position/Title	Supervisor's Name	

EMPLOYEE GENDER
☐1007 - Male ☐1009 - Full- Time
☐100 Female ☐1010 - Part- Time

EMPLOYEE STATUS
☐1011- Temporary (FT - PT) ☐1013- Non-County Employee
☐1012- Volunteer

Incident Date	Time of Incident ☐ AM or ☐ PM	Incident Location
Vehicle Year / Model or Other Property Description		Seat belts used ☐ YES ☐ NO
VIN or Serial #		Asset #
DescribeProperty Damages		Employee cited ■ YES ☐ NO
Passengers Name and Address		
Personal Injury ☐ YES ☐ NO Describe:		

NUMBER OF HOURS INTO SHIFT
☐1024- 0-1 Hour ☐1025- 2-3 Hours ☐1026- 4-5 Hour ☐1027- 6-7 Hours ☐1028- 8-9 Hours ☐1029- 10 Hours or more

DESCRIPTION OF INCIDENT IN THE EMPLOYEE's WORDS (Print or Type and Attach Additional Statements)

C. Other Driver, Claimant, Other Party, or Other Owner Information: Attach Statements of Non-County Employees

Name, Address, and Telephone Number

Insurance Company / Policy #:

Personal Injury ■ YES ☐ NO Describe:

Vehicle Year / Model or Other Property Description VIN or Serial #

Describe Property Damages Claimant statement attached ☐ YES ■ NO

Employee Signature	Today's Date	Date Reported to Supervisor

S&E REPORT **SUPERVISOR'S INVESTIGATION REPORT** **(Complete within 24 hours)**

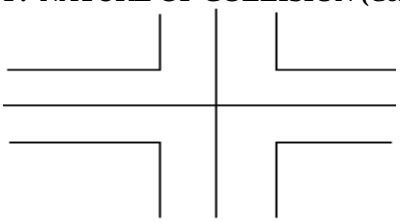
D. WITNESSES: List Names, Addresses, and Phone Numbers. Attach Witness Statements. Get them before they forget.

E. INJURY/ILLNESS/EXPOSURE TREATMENT/OUTCOME

☐ 1136 - First Aid Treatment ☐ 1138 - Medical Treatment Provided by: _____ ☐ 1139 - No Treatment Required

☐ 1137- Lost Workdays ☐ 1140 - Restriction of Work Activities ☐ Yes ☐ No

F. NATURE OF COLLISION (Complete/modify diagram/provide pictures)



Type	Road Surface	Weather Conditions
☐ 1141 - Single Vehicle	☐ 1147 - Wet	☐ 1152 - Clear
☐ 1142 - Multi-Vehicles	☐ 1148 - Dry	☐ 1153 - Cloudy
☐ 1143 - Parked Vehicle	☐ 1149 - Snow or Ice	☐ 1154 - Foggy
☐ 1144 - Heavy Equip.	☐ 1150 - Mud or Other	☐ 1155 - Raining
☐ 1145 - Backing	☐ 1151 - Unknown	☐ 1156 - Snowing
☐ 1146 - Other: _____		☐ 1157 - Other/Unknown

INVESTIGATION

Check All Boxes That Apply:	***DIRECT CAUSES***	**BASIC CAUSES**
UNSAFE ACTS OF INDIVIDUAL	***UNSAFE CONDITIONS OF WORK AREA OR EQUIP.***	**AREAS FOR DEPARTMENT/ SUPERVISOR/INDIVIDUAL IMPROVEMENTS because of**
☐ Failure to follow procedures	☐ Inadequate guards or protection	☐ Inadequate hiring/placement practices
☐ Failure to use safe practice or personal protective equipment	☐ Defective tools, equipment, machine or vehicle	☐ Procedures not enforced or inadequate training/procedures
☐ Physical or mental limitations	☐ Congested work area/roadways	☐ Improper layout or design of work area
☐ Improper Lifting, lowering or carrying technique	☐ Unsafe floors, ramps, stairways, platforms	☐ Inadequate job planning or worksite hazard analysis by supervisor
☐ Removed safety devices	☐ Poor housekeeping	☐ Lack of preventive maintenance
☐ Operating vehicle, equipment or machine at unsafe speed or unsafe manner	☐ Hazardous atmosphere: gases, dust, fumes, vapors or inadequate ventilation	☐ Unsafe design of equipment or work area
☐ Unaware of hazards or operating without authority	☐ Inadequate warning system	☐ Vehicle or equipment inspection process not adequate or not enforced
☐ Unsafe act of non-employee	☐ Limited visibility or adverse weather	☐ Employee insubordination or dishonesty or substance abuse
☐ Horseplay	☐ Poor road conditions	☐ Pre-existing physical condition
☐ Other-EXPLAIN:	☐ Other-EXPLAIN:	☐ Other-EXPLAIN:
☐	☐	☐
☐	☐	☐
☐	☐	☐

Using careless, hazard of job, and N/A are not acceptable investigation terms. Attach additional statements and reports.

ACTIONS

Direct Causes: WHAT ACTIONS WERE TAKEN TO REMOVE DIRECT CAUSES OR WHAT HAPPENED IN DEPARTMENT?	Who Completed this Action?	DATE COMPLETED
Basic Causes: WHAT ACTIONS WERE TAKEN TO REMOVE BASIC CAUSES? LIST ANY SAFETY PRACTICES THAT CAN BE PERFORMED TO HELP PREVENT REOCCURRENCE IN DEPARTMENT.	**Who Completed IT & WHO Affected in Department By these Corrective Actions**	**DATE COMPLETED**

Print Supervisor/Investigator Name	Supervisor Signature	Investigation Date	Date Notified of Accident

Department Accident Audit Checklist: (Complete within 48 hours or request 5 days extension. Email to Risk Management at rmclaims@horrycounty.org.)

Check Basic Procedures & Risk Management Standards Completed

☐Y ☐N Sent accident report to Risk Management within 24 hours.
☐Y ☐N Completed investigation
☐Y ☐N Completed corrective actions.
☐Y ☐N Sent copy of any employee medical restrictions to Risk Management and used light duty program to comply with restrictions from doctor if applicable.
☐Y ☐N Used designated doctor – Doctors Care.
☐Y ☐N ☐N/A Completed post-vehicle accident drug screen within 24 hours. Date: _____
☐Y ☐N ☐N/A Completed Driver alcohol screen within 2 hours. Date: _____
☐Y ☐N ☐N/A Took vehicle to Fleet Service or Fleet designated Body Shop within 24 hours or (next business day). Date completed

Supervisor Self Compliance Audit and Risk Management Checklist

1. Accident Date:	2. Accident Time:	☐ AM ☐ PM
3. Employee and/or Claimant Name:		
4. Date Notice of Accident Received by Supervisor or Supervisor-in-charge:		Within 24 Hrs? ☐ Y ☐ N
5. Investigation of All Causes Determined? ☐ Y ☐ N Describe causes/what happened.		
6. Confirm actual actions/corrections taken. What was done? What is the Status? Who benefited from the changes and how are similar accidents in your department prevented?		7. Dates Completed?
8. Designated Physician – Doctors Care Used? ☐ Yes ☐No		If not used, why not?
9. Light Duty Used: ☐ Yes ■ No		10. Describe light duty assignment.
11. Audit requires Department Head, Asst. County Administrator, or County Administrator Signature:		12. Date Reviewed:

Attention Supervisor: Please complete this form for a drug screen/alcohol testing

POST VEHICLE ACCIDENT - AUTHORIZATION FORM

Employee Name:
Date of Accident:

Employer: Horry County Government Dept:

Is a **drug screen** required? ☒ Yes ☐ No If Yes, What type?

Is **alcohol screening** required? (If CDL) ☐ Yes ☒ No

Has employer filled out First Report of Injury? ☐ Yes ☒ No

This certifies that the above information is correct. I authorize the medical provider to provide the above testing for the employee as "marked"

This section to be completed by supervisor

Did supervisor accompany employee to the medical facility? ☒ YES ☐ No

(Failure to check will indicate a "no" response)

Supervisor's Signature_____

Please Print Name:

Position/Title: Date: