

CHAPTER 7 – SAFETY

A. Introduction

1. It is the policy of the Town that all work areas and working conditions be kept safe and all hazards eliminated. The Human Resources Director shall be responsible for implementing safety polices which shall be adopted by Administrative Policies. Safety suggestions from all employees will be welcomed and encouraged.
2. A Safety Committee shall meet on at least a quarterly basis.
3. Safety Committee meetings shall be held at a predetermined date and time to accomplish the following:
 - a. Review and discuss accident summary reports to suggest corrective action;
 - b. Evaluate all hazards and recommendations uncovered through inspections and make recommendations to the Town Administration for corrections considered necessary for the safety of persons or operations;
 - c. Help formulate safety rules for safe operation and recommend same to the Town Manager or designee for adoption; and
 - d. Assist in planning activities that will stimulate and maintain the interest of employees in the safety program.
4. An employee who is injured or in an accident in the performance of his/her duties shall immediately report the injury/accident to his/her supervisor and shall complete the first report of injury form (below) provided for such injuries/accidents.

FIRST REPORT OF INJURY OR ILLNESS

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION**

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)		Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)		
TELEPHONE Area Code Number				
OCCUPATION				
DATE OF BIRTH ____/____/____	SEX <input type="checkbox"/> M <input type="checkbox"/> F			
		INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED	

EMPLOYER INFORMATION

COMPANY NAME: _____ D. B. A.: _____ Street: _____ City: _____ State: _____ Zip: _____		FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
TELEPHONE Area Code Number		NATURE OF BUSINESS	POLICY/MEMBER NUMBER
EMPLOYER'S LOCATION ADDRESS (If different) Street: _____ City: _____ State: _____ Zip: _____ LOCATION # (If applicable) _____		DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____ COUNTY OF ACCIDENT _____		LAST DATE EMPLOYEE WORKED ____/____/____ RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
		DATE OF DEATH (If applicable) ____/____/____	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO Number of hours per day _____ Number of hours per week _____ Number of days per week _____
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 440.105(7), F.S. I have reviewed, understand and acknowledge the above statement.		AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
EMPLOYEE SIGNATURE (If available to sign) _____ EMPLOYER SIGNATURE _____		DATE _____ DATE _____	AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached	<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3)
<input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached	Employee's 8 TH Day of Disability _____/_____/_____ Entity's Knowledge of 8 TH Day of Disability _____/_____/_____ <input type="checkbox"/> 3. Lost Time Case - 1st day of disability _____/_____/_____ Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date _____/_____/_____ Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate _____ <input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY Penalty Amount Paid in 1 st Payment \$ _____ Interest Amount Paid in 1 st Payment \$ _____

REMARKS:			INSURER NAME
			CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	
SERVICE CODE/PA CODE #	CLAIMS-HANDLING ENTITY FILE #		

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

B. Safety Rules

An Employee Safety Manual is available in each Town department. Every employee shall be familiar with and adhere to the rules that may apply to their job responsibilities.

ACKNOWLEDGEMENT/RECEIPT OF POLICIES AND PROCEDURES MANUAL

I have this day received a copy of the Town of Surfside Employee Policies and Procedures Manual (the "Manual") and I understand that I am responsible for reading the Town's policies and practices described therein. I understand that the Manual replaces any and all prior policies and practices of the Town.

I agree to abide by the policies and procedures contained in the Manual. I understand that the policies and benefits contained in the Manual may be added to, deleted or changed by the Town at any time. I understand that neither the Manual nor any other written or verbal communication is intended to in any way create a contract of employment, and that the Manual is for informational purposes only. I also understand that the employment with the Town is at-will for the first two (2) years, which permits the Town or the employee to terminate the employment relationship at any time, for any reason, with or without notice.

If I have any questions regarding the content or interpretation of the Manual, I will bring them to the attention of my supervisor and/or the Human Resource Director.

EMPLOYEE NAME (Print) _____

EMPLOYEE SIGNATURE _____

DATE _____