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OGEMAW COUNTY CLERK
GARY R. KLACKING

CHERYL MOLLARD
ADMIN. ASSISTANT

COUNTY OF OGEMAW
34th JUDICIAL CIRCUIT

September 22, 2000

TO: ELECTED OFFICIALS/COUNTY DEPARTMENT HEADS

FROM: GARY R. KLACKING

RE: REPORTING REQUIREMENTS –
OCCUPATIONAL INJURIES/ILLNESSES

This memo concerns MIOSHA statutory reporting requirements for the occurrence of occupational (work-related) injuries and/or illness. It also concerns the *Incident Report* form to be used when sending employees to Evergreen Clinic for treatment.

Please be advised, unless a work-related injury is life threatening, all employees should report to **Evergreen Clinic** for treatment. **Evergreen Clinic** is located at 611 Court Street (South M-30), West Branch, Michigan.

In the event of a work-related injury/illness, the attached forms, ***MIOSHA – 101 & Accident Fund's "Employee Accident Investigation Report"*, must be received in our office within six (6) days** of the date of the incident. Please abide by the six-day reporting requirement. Significant fines and penalties can be levied on municipalities for non-compliance with the act.

Additionally, the attached ***Incident Report Form*** (Part A & B) must accompany any employee going to Evergreen Clinic for treatment.

Your cooperation and consideration in this matter is appreciated. Should you have any questions please contact our office.

MIOSHA No. 101
Case or File No. _____

Form Approved
OMB No. 44R 1453

Supplementary Record of Occupational Injuries and Illnesses

EMPLOYER

1. Name _____
2. Mail address _____
(No. and street) (City or town) (State)
3. Location, if different from mail address _____

INJURED OR ILL EMPLOYEE

4. Name _____ Social Security No. _____
(First name) (Middle name) (Last name)
5. Home address _____
(No. and street) (City or town) (State)
6. Age _____ 7. Sex: Male _____ Female _____ (Check one)
8. Occupation _____
(Enter regular job title, not the specific activity he was performing at time of injury.)
9. Department _____
(Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS

10. Place of accident or exposure _____
(No. and street) (City or town) (State)
If accident or exposure occurred on employer's premises, give address of plant or establishment in which it occurred. Do not indicate department or division within the plant or establishment. If accident occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of injury as accurately as possible.
11. Was place of accident or exposure on employer's premises? _____ (Yes or No)
12. What was the employee doing when injured? _____
(Be specific. If he was using tools or equipment or handling material, name them and tell what he was doing with them.)
13. How did the accident occur? _____
(Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

OCCUPATIONAL INJURY OR OCCUPATIONAL ILLNESS

14. Describe the injury or illness in detail and indicate the part of body affected. _____
(e.g.: amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)
15. Name the object or substance which directly injured the employee. (For example, the machine or thing he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his skin; or in cases of strains, hernias, etc., the thing he was lifting, pulling, etc.)
16. Date of injury or initial diagnosis of occupational illness _____
(Date)
17. Did employee die? _____ (Yes or No)

OTHER

18. Name and address of physician _____
19. If hospitalized, name and address of hospital _____

Date of report _____ Prepared by _____
Official Position _____

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES

To supplement the Log of Occupational Injuries and Illnesses (MIOSHA No. 200), each establishment must maintain a record of each recordable occupational injury or illness. Workers' Disability Compensation Form 100, insurance or other reports are acceptable as records if they contain all facts listed below or are supplemented to do so. Only Workers' Disability Compensation Form 100's revised on, or subsequent to, August, 1972 will be acceptable as a record; unless, supplemented to contain all facts listed below. If no suitable report is made for other purposes, this form (MIOSHA No. 101) may be used or the necessary facts can be listed on a separate plain sheet of paper. These records must also be available in the establishment without delay and at reasonable times for examination by representatives of the Department of Labor and the Department of Public Health. The records must be maintained for a period of not less than five years following the end of the calendar year to which they relate.

Such records must contain at least the following facts:

1) *About the employer*—name, mail address, and location if different from mail address.

2) *About the injured or ill employee*—name, social security number, home address, age, sex, occupation, and department.

3) *About the accident or exposure to occupational illness*—place of accident or exposure, whether it was on employer's premises, what the employee was doing when injured, and how the accident occurred.

4) *About the occupational injury or illness*—description of the injury or illness, including part of body affected; name of the object or substance which directly injured the employee; and date of injury or diagnosis of illness.

5) *Other*—name and address of physician; if hospitalized, name and address of hospital; date of report; and name and position of person preparing the report.

SEE *DEFINITIONS* ON THE BACK OF MIOSHA FORM 200.

Accident Fund Company
The WorkSafe People
232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
(517) 342-4200

Employee Accident Investigation Report

This form is to be completed by the injured employee and the supervisor in charge at the time of the accident.

FACILITY

NAME	CITY	STATE	LOCATION #

EMPLOYEE

NAME	SEX	D.O.B.	HEIGHT	WEIGHT
		/ /		

SOCIAL SECURITY #	HIRE DATE	FULL TIME	PART TIME	SHIFT: DAY	EVENING	NIGHT
— —	/ /	☐	☐	☐	☐	☐

DEPARTMENT	ADDRESS	
JOB CLASSIFICATION	CITY, STATE	HOME PHONE # ( )

DESCRIPTION OF ACCIDENT

ACCIDENT DATE	ACCIDENT TIME	ACCIDENT LOCATION
/ /	: a.m. ☐ p.m. ☐	

Please describe the accident, including what employee was doing when it occurred.

Name object or substance that directly attributed to the accident.

What caused the accident? How could it have been prevented?

Describe the injury.

BODY PART

- ☐ 1. Abdomen
- ☐ 2. Ankle(s)
- ☐ 3. Back
- ☐ 4. Buttock(s)
- ☐ 5. Calf(s)
- ☐ 6. Chest
- ☐ 7. Ear(s)
- ☐ 8. Elbow(s)
- ☐ 9. Eye(s)
- ☐ 10. Face
- ☐ 11. Finger(s)
- ☐ 12. Foot
- ☐ 13. Forearm(s)
- ☐ 14. Groin
- ☐ 15. Hand(s)
- ☐ 16. Head
- ☐ 17. Hip(s)
- ☐ 18. Jaw
- ☐ 19. Knee(s)
- ☐ 20. Leg(s)
- ☐ 21. Lungs
- ☐ 22. Mouth
- ☐ 23. Neck
- ☐ 24. Nose
- ☐ 25. Ribs
- ☐ 26. Shoulder(s)
- ☐ 27. Spine
- ☐ 28. Stomach
- ☐ 29. Teeth
- ☐ 30. Thigh(s)
- ☐ 31. Throat
- ☐ 32. Thumb(s)
- ☐ 33. Toe
- ☐ 34. Upper Arm(s)
- ☐ 35. Whole Body
- ☐ 36. Wrist(s)

CONDITION

- ☐ 1. Abrasion
- ☐ 2. Amputation
- ☐ 3. Avulsion
- ☐ 4. Blister
- ☐ 5. Burn
- ☐ 6. Contusion
- ☐ 7. Death
- ☐ 8. Dermatitis
- ☐ 9. Foreign Object
- ☐ 10. Fracture
- ☐ 11. Frostbite
- ☐ 12. Ganglion
- ☐ 13. Grinding Wound
- ☐ 14. Hearing Loss
- ☐ 15. Heart Attack
- ☐ 16. Heat (cramps, stroke)
- ☐ 17. Hernia
- ☐ 18. Infection
- ☐ 19. Insect Bite
- ☐ 20. Irritation (dust)
- ☐ 21. Irritation (vapor)
- ☐ 22. Laceration
- ☐ 23. Pulmonary Condition
- ☐ 24. Puncture Wound
- ☐ 25. Repetitive Motion Disorder
- ☐ 26. Scratch
- ☐ 27. Sliver
- ☐ 28. Splinter
- ☐ 29. Sprain/Strain
- ☐ 30. Slip/Fall
- ☐ 31. Other _____

Corrective actions taken to prevent reoccurrence.

Treatment

- ☐ First Aid
- ☐ Panel of Physicians
- ☐ Emergency Room
- ☐ Personal Physician/Clinic
- ☐ Refused Treatment
- ☐ Other (name) _____

Lost Time? ☐ Yes ☐ No	Number of Days:	Modified/Restricted Duty ☐ Yes ☐ No	NUMBER OF DAYS

Did employee accept medical treatment? ☐ Yes ☐ No	Was employee hospitalized? ☐ Yes ☐ No	Did employee return to work the same day? ☐ Yes ☐ No

Report Date / /	Employee Signature	Supervisor Signature

LC-8 Rev. 4/91 **(THIS IS NOT A CLAIM FORM - TO BE USED ONLY FOR INTERNAL ACCIDENT PREVENTION PURPOSES)**

INCIDENT REPORT

SECTION A: TO BE FILLED OUT BY SUPERVISOR

Employee Name: _____ Dept.: _____

Social Security Number: _____ Sex: _____ Age: _____

Date of Accident: _____ Time of Accident: _____

Address: _____

Street City State Zip Code

Incident Report - (Patient states while at work)

_____

_____

_____

_____

Signature of Supervisor: _____ Date: _____

Consent to Treat and Release Information

I authorize any physician, or medical facility where I consult or am treated to divulge to Ogemaw County all information concerning my medical condition. A photocopy shall be valid as the original.

Employee's Signature: _____ Date:

SECTION B: TO BE FILLED OUT BY THE ATTENDING PROVIDER

Date of First Exam: _____ Date(s) of Follow-up Exam(s): _____

Provisional Diagnosis: _____

Treatment: _____

Restrictions: _____

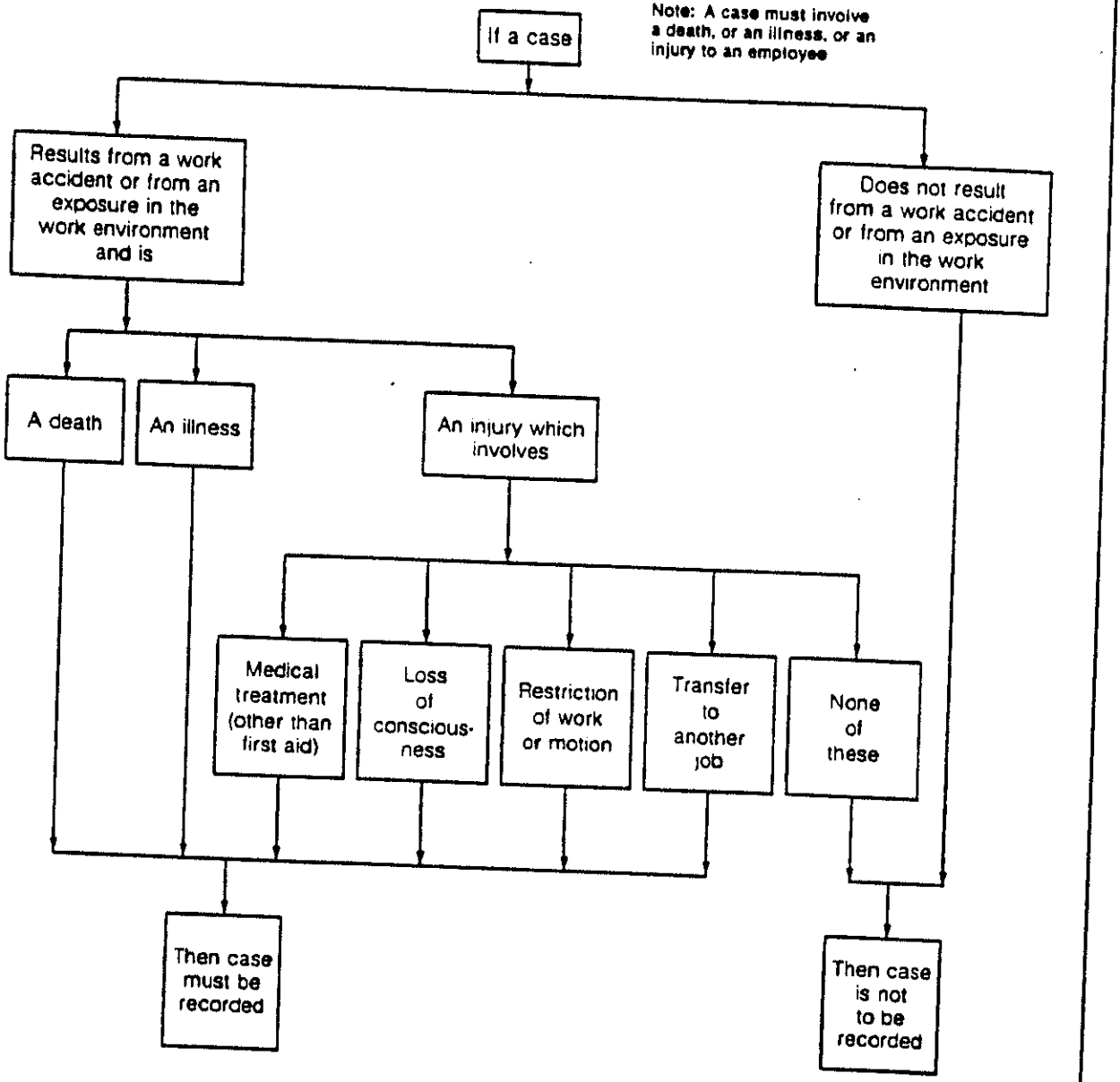
X-Ray: _____ Neg. _____ Pos. _____

Medication and Dose: _____

Recommended Referral: _____

Provider's Signature _____ **Date:** _____

Chart 1. Guide to recordability of cases under the Occupational Safety and Health Act



not be made for the recurrence of symptoms from previous cases, and it is sometimes difficult to decide whether or not a situation is a new case or a recurrence. The following guidelines address this problem:

a. *Injuries.* The aggravation of a previous injury almost always results from some new incident involving the employee (such as a slip, trip, fall, sharp twist, etc.). Consequently, when work related, these new incidents should be recorded as new cases.

b. *Illnesses.* Generally, each occupational illness should be recorded with a separate entry on the OSHA No. 200. However, certain illnesses, such as silicosis, may have prolonged effects which recur over time. The recurrence of these symptoms should not be recorded as new cases on the OSHA forms. The recurrence of symptoms of previous illnesses may require adjustment of entries on the log for previously recorded illnesses to reflect possible changes in the extent or outcome of the particular case.

Some occupational illnesses, such as certain dermatitis or respiratory conditions, may recur as the result of new exposures to sensitizing agents, and should be recorded as new cases.

D. Establishing work relationship

The Occupational Safety and Health Act of 1970