SAFETY POLICY

Cherokee County does have a safety policy and intends to conduct all operations as safely and efficiently as possible. The responsibility, authority and accountability for safety are assigned to all department heads and supervisory personnel within their individual areas of operation.

Robin Caldwell is the Safety Coordinator for the County. All employees and managers are responsible for active participation in the safety program activities; the Coordinator’s role is to support and coordinate this participation to ensure the safety program functions efficiently.

All employees will have the responsibility of performing their own work in a safe and efficient manner and to report unsafe conditions to their department head or supervisor for prompt correction. All employees are also to report all work-related injuries to their supervisor in a timely manner. All work-related injuries, regardless of severity, must be reported to the Human Resources Manager within 24 hours of the injury. A copy of the worker’s compensation report form is on the back of this document.

In the case of vehicle operations, drivers will be expected to follow the principles of “Defensive Driving”, to drive so as to prevent accidents in spite of the incorrect action of others, and in spite of adverse driving conditions.
Employee Name __________________________________ Home Phone __________________

Home Address __________________________________ Cell Phone _________________
(Mailing address, include city)
Number of dependents______  Marital status _______ Date of incident _________________

Time you began work_________  Hours worked per day _____  Days of week worked_______

Where did the incident occur?_____________________________________________________
(give an exact address if you can)

Time of incident________________________  Supervisor’s Name _______________________

Did anyone witness the incident? _______  If so, whom _______________________________

Body part injured (i.e. right knee, left hand, etc)_________________________________________
(be as specific as possible)

Were you using any equipment or tools? ______  If so, what? ___________________________

Describe how injury occurred, giving as much detail as possible _____________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Time incident reported to supervisor __________  Did you receive medical care? __________

If medical care received, give provider name? _________________________________________

Do you have a follow-up appointment? ______  If so, with whom? _______________________

Date of follow-up appointment ______________

Other than the day of the incident, has any work time been missed? ____  How much ________

This form must be completed within 24 hours of time of injury and returned to the Human Resource Director so the incident can be reported to our Worker’s Compensation adjustors. THANK YOU.