

<b>Oregon State Library Policy</b>	
<b>Workplace Safety</b>	
Approved by:	Date: 8/9/11

**Policy Statement:** It is the policy of the Oregon State Library to maintain the productivity, well-being and safety of the agency by providing a safe workplace for employees, volunteers and members of the public. Injury and illness due to accidents and unsafe working conditions are costly and may be preventable; the State Library promotes fundamental safety concepts that minimize occupational hazards.

To facilitate this policy, Library Council will oversee a Safety and Security Committee, established with operating bylaws. The Committee shall be responsible for making recommendations to improve safety and security in the workplace.

**Authority:** ORS 654, OAR 437-001-700 and DAS/SEIU Article 101.5 Safety and Health (Section 1)

**Applicability:** State Library employees, volunteers and State Library Board of Trustees

**Attachments:**

- Workplace Safety Commitment Form (Attachment A)
- Incident, Accident and Injury Report Form (Attachment B)
- Report of Job Injury or Illness Workers' Compensation Claim – SAIF 801Form (Attachment C)

**Definitions:**

**Evacuation Coordinator:** Staff members who have agreed to coordinate the evacuation of people from designated areas of the building.

**Emergency Red Book:** State Library emergency manual that includes emergency and incident response procedures.

**Emergency Response Card:** State Library emergency resource cards with quick instructions on how to respond in a Bomb Threat, Earthquake, Chemical Spill; Accident or Medical Emergency, Fire, and Disruptive or Dangerous people emergency situation and are located near telephones at all workstations.

**Emergency Notification Drill:** Drill conducted using telephone or instant messaging.

**Mall Security:** Oregon State Police located at the Capitol.

**OR-OSHA:** Oregon Occupational Safety and Health Administration (OR-OSHA) Division enforces the state's workplace safety and health rules.

**SAIF:** State Accident Insurance Fund (SAIF) is the state's Workers'

Compensation Insurance Company.

**Policy:**

1. The Safety and Security Committee will:
  - Report on safety and security activities to Library Council as required. Conduct
  - quarterly safety inspections of the building using the OR-OSHA guidelines. Report or submit potential safety hazards to Library Council and Management Team with any recommended action.
  - Maintain and administer an agency evacuation plan for use by the State Library Evacuation Coordinators during all emergency evacuation situations.
  - Provide training for Evacuation Coordinator members and ensure they have the necessary equipment needed to carry out their duties during an emergency.
  - Review and update the Emergency Red Book, as needed, and provide at least one copy to each Team.
  - Conduct one fire drill, one earthquake drill and one emergency notification drill each year.
  
2. All new employees and volunteers receive an emergency procedures orientation. In addition, they shall review and sign the Workplace Safety Commitment Form (Attachment A), which provides a list of safety practices designed to help prevent serious injuries.
  
3. Emergency Response Cards are located near telephones at all workstations in the State Library. Employees and volunteers are required to follow the directions on the card and to properly notify 911, Mall Security and a Management Team member as appropriate in an emergency.

**Safety Responsibilities:**

1. Employees incident reporting:
  - The employee involved in an incident **or** the on-the-scene State Library staff member completes the Incident, Accident and Injury Report Form (Attachment B), as soon as possible, and notifies a Program Manager.
  - The Program Manager follows up with the injured person, reviews the completed Incident Form, submits the original Incident Form to the Business Manager **within 24 hours** and notifies the Human Resources Manager of the incident.
  - If an employee's injury requires doctor's treatment, the employee completes the Worker top section of the Report of Job Injury or Illness Workers' Compensation Claim – SAIF 801 Form (Attachment C) and submits it to the Human Resources Manager. The Human Resources Manager completes the Employer bottom section of the SAIF 801 Form, gives a copy of the form to the employee, notifies SAIF Corporation **within five (5) days** of knowledge of an employee injury, tracks incident on the Incident Report log and follows up with appropriate parties.
  - The Human Resources Manager completes and submits OSHA 300 annual reports.

2. Volunteers incident reporting:
  - A volunteer's injury may be covered under the Volunteer Injury Coverage (VIC) through the Department of Administrative Services, Risk Management Division.
  - The volunteer completes the Incident, Accident and Injury Report Form (Attachment B), as soon as possible, and notifies the Agency Volunteer Coordinator, Team Volunteer Coordinator, the Program Manager, or the Human Resources Manager.
  - The volunteer works directly with Risk Management Division staff at (503) 373-7475 and the State Library Agency Volunteer Coordinator.
3. Safety Analysis (Investigation) of Accident/Incident:
  - The Business Manager completes the corrective/preventative action investigation and reports incident to the Safety and Security Committee and submits the original form to the Human Resources Manager.
  - Human Resources Manager follows up with the injured employee.
4. The Safety and Security Committee shall identify safety and security hazards in the State Library building based on building inspection tours and suggestions from employees and volunteers. The Committee will submit hazard identification reports to Library Council and Management Team.
5. The Safety and Security Committee will help identify employee and volunteer safety training needs and recommend safety training to Library Council and Management Team.
6. All employees and volunteers are encouraged to report hazardous conditions or other safety and security concerns to any member of the Safety and Security Committee, Library Council or Management Team.
7. Safety and Security Committee members will report safety and security activities and consider improvements with their team at least quarterly.
8. Final authority and funding for all safety and security procedures, training and hazard elimination is the responsibility of the Management Team.



## WORKPLACE SAFETY COMMITMENT FORM

The safety practices in the Workplace Safety Commitment are designed to help prevent serious injuries to yourself and others. The State Library takes an active interest in the safety of its employees and volunteers. Please take a few minutes to review this brief overview of work area precautions.

### THE MOST COMMON WAYS TO BE INJURED ON THE JOB

- Improper lifting
- Improper housekeeping
- Improper use of safety equipment
- Tripping
- Using faulty equipment
- Failing to report safety risks

### SAFETY—A MATTER OF COMMON SENSE

Discuss work procedures with your manager before beginning work assignments.

Read and review OSL emergency procedures.

Know how to report and respond to emergencies.

Know proper evacuation procedures and designated evacuation meeting area.

Know and follow security procedures.

Correct or immediately report any unsafe conditions or practices to your manager.

Report building maintenance issues to the Administration office.

Maintain your work area. Keep it clean and organized.

Share ideas and suggestions on how to improve the safety environment with your manager.

Take advantage of safety training when available.

Watch footing to avoid slips and falls.

Notify DAS custodial of any spills.

Keep walkways clear of debris, tools and materials.

Secure ladders before climbing. Check for defects. Always face the ladder when going up or down.

Do not use unstable objects (buckets, chairs, tables, etc.) for work platforms or ladders.

Watch your back! Get help when lifting heavy loads. Use proper positioning – keep your back straight, lift with your legs, and carry the load close to your body. Never twist your back while lifting or carrying a load.

Watch your balance when pulling, pushing, or prying – especially in an elevated work area.

No horseplay.

Do not jump from elevated areas.

Wear protective equipment (eye guards, gloves, etc.) as required, for your own protection.

Wear suitable shoes in good repair.

Verify electrically powered equipment is properly grounded. Notify your manager if electrical cords look unsafe.

Do not operate, repair or adjust mechanical or electrical equipment unless you are authorized and qualified.

Use the proper tools when doing any job.

Obey traffic regulations while driving vehicles or equipment.

Read caution labels on cleaning agents, solvents or flammables. Understand the hazards involved, and take the necessary precautions.

I (print name) \_\_\_\_\_ have received, read and understand the Workplace Safety Commitment and agree to abide by its safety practices. I further understand that I am to report any incident or injury to my program manager. (Please check one)

- I realize as an **employee** of the State Library that violation of the workplace safety practices may lead to disciplinary action up to and including dismissal.
- I realize as a **volunteer** that violating the workplace safety practices may end my volunteer service agreement with the State Library.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Updated 7/14/2014



**Incident, Accident, & Injury  
Report Form**

**INCIDENT, ACCIDENT, & INJURY REPORT FORM**

(COMPLETE AND SUBMIT FORM TO BUSINESS MANAGER WITHIN 24 HOURS OF INCIDENT)

<input type="checkbox"/> OSL Employee <input type="checkbox"/> Patron <input type="checkbox"/> OSL Volunteer <input type="checkbox"/> Public	(List all persons involved in incident. Use back of form if necessary)	
	NAME: _____ PHONE: _____ ADDRESS: _____	
DATE & TIME OF INCIDENT, A.M. OR P.M.:	LOCATION OF INCIDENT:	
Describe Incident or Accident in Detail:		
TYPE OF INJURY (if any):		
WITNESS NAMES:	NAME: _____ PHONE: _____ NAME: _____ PHONE: _____ NAME: _____ PHONE: _____	
ACTION TAKEN:	<input type="checkbox"/> Called 911 <input type="checkbox"/> Called State Police <input type="checkbox"/> Name of Officer: _____ <input type="checkbox"/> Notified Management <input type="checkbox"/> Notified emergency contact person <input type="checkbox"/> First Aid Administered <input type="checkbox"/> Injured person refused assistance <input type="checkbox"/> No Action Taken <input type="checkbox"/> Other _____	
Describe Steps Taken:		
<p><b>NOTE:</b> If the job injury requires doctor's treatment, the employee completes the Report of Job Injury or Illness Workers' Compensation Claim – SAIF 801 Form and submits the form to the Human Resources Manager.</p> <p><i>An injured volunteer submits the Incident, Accident, &amp; Injury Form and works with the Program Manager, Volunteer Program Coordinator, Human Resources Manager, and the VIP Risk Management Representative.</i></p>		

Name of preparer of this report

Date

**Business Manager to Complete Section Below**

<u>CORRECTIVE ACTION RECOMMENDED</u>
<u>PREVENTIVE ACTION RECOMMENDED</u>

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**Business Manager**

**Date**

**INCIDENT REPORT PROCEDURE:**

- STEP 1 Injured employee or the on the scene State Library staff member prepares the Incident Form, as soon as possible, and notifies Program Manager.
- STEP 2 Program Manager follows up with employee and reviews Incident Form then submits original Incident Form to the Business Manager within 24 hours and notifies the Human Resources Manager of the incident.
- STEP 3 Business Manager completes corrective/preventative action investigation and reports incident to Safety and Security Committee and submits original form to Human Resources Manager.
- STEP 4 Human Resources Manager follows up with injured employee.
- STEP 5 If injury requires doctor's treatment, employee completes Worker section of the Report of Job Injury or Illness Workers' Compensation Claim – SAIF 801 Form and submits the form to the Human Resources Manager.
- STEP 6 Human Resources Manager completes Employer section of the SAIF 801 Form and gives a copy of the form to the worker. Notifies SAIF Corporation within five (5) days of knowledge of the claim and data enters incident on the Incident Report log.

**saifcorporation**  
400 High St. SE, Salem, OR 97312



**For SAIF Customer Use**

Area \_\_\_\_\_  
Dept. \_\_\_\_\_  
Shift \_\_\_\_\_ CC \_\_\_\_\_

CLAIM NO. \_\_\_\_\_  
SUBJECT DATE \_\_\_\_\_  
CLASS \_\_\_\_\_  
DEFAULT DATE \_\_\_\_\_  
EMPLOYER'S ACCOUNT NO. \_\_\_\_\_

Toll-free phone: 1.800.285.8525  
Toll-free FAX: 1.800.475.7785

**Report of Job Injury or Illness**  
Workers' compensation claim

**Worker**

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line. Your employer will give you a copy.

1. Date of injury or illness: _____	2. Date you left work: _____	3. Time you began work on day of injury: _____ a.m. _____ p.m.	4. Regularly scheduled days off: _____ M T W T F S S	<b>DEPT USE:</b> Emp _____ Ins _____ Occ _____ Nat _____ Part _____ Ev _____ Src _____ 2src _____
5. Time of injury or illness: _____ a.m. _____ p.m.	6. Time you left work: _____ a.m. _____ p.m.	7. Shift on day of injury: _____ (from) _____ a.m. _____ p.m. (to) _____ a.m. _____ p.m.		
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) _____ <input type="checkbox"/> Left <input type="checkbox"/> Right			9. Check here if you have more than one job: <input type="checkbox"/>	
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				

*Information ABOVE this line: date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.*

11. Your legal name: _____	12. Worker's language preference other than English: _____ <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify): _____	13. Birthdate: _____	14. Gender: _____ <input type="checkbox"/> M <input type="checkbox"/> F
15. Your mailing Address _____ City _____ State _____ Zip _____	16. Home phone: _____		
17. Social Security no. (see back*): _____	18. Occupation: _____	19. Work phone: _____	
20. Names of witnesses: _____			
21. Name and phone number of health insurance company: _____		22. Name and address of health care provider who treated you for the injury or illness you are now reporting: _____	
23. Have you previously injured this body part? <input type="checkbox"/> Yes <input type="checkbox"/> No			
24. Were you hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
26. By my signature, I am making a claim for worker's compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. <b>Notice:</b> Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(j)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.			
27. Worker signature: _____	28. Completed by (please print): _____	29. Date: _____	

**Employer**

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

30. Employer legal business name: _____	31. Phone: _____	32. FEIN: _____
33. If worker leasing company, list client business name: _____	34. Client FEIN: _____	
35. Address of principal place of business (not P.O. Box): _____	36. Insurance policy no.: _____	
37. Street address from which worker is/was supervised: _____ ZIP: _____	38. Nature of business in which worker is/was supervised: _____	
39. Address where event occurred: _____		
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		41. Class code: _____
42. Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Did injury occur during course and scope of job? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No	44. OSHA 300 log case no: _____
45. Date employer knew of claim: _____	46. Worker's weekly wage: \$ _____	47. Date worker hired: _____
48. If fatal, date of death: _____	49. Return-to-work status: Not returned <input type="checkbox"/> Regular Date: _____ Modified Date: _____	
50. If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No		51. Date: _____
51. Employer signature: _____	52. Name and title (please print): _____	53. Date: _____

**801**

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**OSHA requirements:** On the job fatalities and catastrophes must be reported to Oregon OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to Oregon OSHA. Call 800.922.2689, 503.378.3272, or Oregon Emergency Response 800.452.0311, on nights and weekends.

**801**

RESET

PRINT

## A guide for workers recently hurt on the job

The following information is provided by SAIF Corporation at the request of the Workers' Compensation Division

**saif**corporation

400 High St. SE, Salem, OR.97312

### How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete Form 801, "Report of Job Injury or Illness," available from your employer and Form 827, "Worker's and Physician's Report for Workers' Compensation Claims," available from your health care provider.

### How do I get medical treatment?

- You may receive medical treatment from the health care provider of your choice, including:
  - Authorized nurse practitioners
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

### Are there limitations to my medical treatment?

- Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work. Check with your health care provider about any limitations that may apply.
- If your claim is denied, you may have to pay for your medical treatment.

### If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

### What if I have questions about my claim?

- SAIF Corporation or your employer should be able to answer your questions. Call SAIF Corporation at 800.285.8525.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

**Ombudsman for Injured Workers:**

**An advocate for injured workers**

Toll-free: 800.927.1271

Email: [oiw.questions@state.or.us](mailto:oiw.questions@state.or.us)

**Workers' Compensation Compliance Section**

Toll-free: 800.452.0288

Email: [workcomp.questions@state.or.us](mailto:workcomp.questions@state.or.us)

- **Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?**  
You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).