Town of Georgia

Employee Injury Reporting & Incident Review Process Guide

(Including OSHA Reporting Requirements)as of October 10, 2025

Purpose

To ensure all employee injuries and work-related incidents are reported, documented, and reviewed promptly and accurately, in compliance with:

- Town of Georgia Injury Reporting, Medical Treatment & Incident Review Policy (Approved October 28, 2019)
- Vermont Occupational Safety and Health Administration (VOSHA/OSHA) requirements as of October 10, 2025
- PACIF (VLCT) workers' compensation reporting requirements as of October 10, 2025

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1 Immediate Actions – At the Time of Injury

Responsible: Injured Employee & Supervisor

Step	Action	Responsible Party	Timeline
1.1	**Ensure safety first.** Stop work immediately. Move away from hazards.	Employee / Co-workers	Immediately
1.2	**Seek medical attention.** Call 911 for serious injury or direct employee to healthcare provider.	Supervisor	Immediately
1.3	**Notify supervisor.** Report the injury verbally as soon as possible.	Employee	Immediately
1.4	**Secure the scene.** Supervisor prevents tampering with equipment or area until review.	Supervisor	Immediately

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2 Medical Treatment & Documentation

Responsible: Supervisor, Employee, Healthcare Provider

Step	Action	Responsible Party	Timeline
2.1	Employee receives care and obtains a **Work Capability Form** (VT Dept. of Labor Form 20 or equivalent).	Employee / Provider	Same day
2.2	Supervisor provides or helps obtain the correct form if needed.	Supervisor	Within 24 hours
2.3	Employee submits completed form to supervisor upon return.	Employee	Upon return to work

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3 Completing the Injury/Incident Report

Responsible: Supervisor & Employee

Step	Action	Responsible Party	Timeline
3.1	**Complete Injury/Incident Form.** Supervisor and employee fill out the **Employee Injury Report & Incident Review Form.**	Supervisor & Employee	Within 24 hours
3.2	Gather all facts: who, what, when, where, how, cause, witnesses, and corrective actions.	Supervisor	Within 24 hours
3.3	Both parties sign and attest to accuracy.	Supervisor & Employee	Same day
3.4	Attach supporting documents (photos, witness statements, medical forms).	Supervisor	Within 24 hours

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4 Filing the Claim & OSHA/VOSHA Reporting

Responsible: Supervisor, Town Administrator, Department Head

Step	Action	Responsible Party	Timeline
4.1	Submit completed **Employee Injury/Incident Form** and all attachments to the **Town Administrator**.	Supervisor	Within 24 hours
4.2	Town Administrator files workers' compensation claim with **PACIF** (VLCT), *not the State of Vermont.*	Town Administrator	Immediately
4.3	**OSHA/VOSHA Reporting:** Determine if the incident meets OSHA's recordable or reportable criteria (see below).	Town Administrator / Dept. Head	Within 24 hours
4.4	If reportable, contact **VOSHA** or **OSHA** as required by federal regulation: • **Fatalities:** Report within **8 hours** of learning of the death. • **In-patient Hospitalization, Amputation, or Eye Loss:** Report within **24 hours.**	Town Administrator	Immediately
4.5	Reports must be submitted by calling OSHA (1-800-321-6742), reporting online at www.osha.gov/report, or contacting the nearest VOSHA office.	Town Administrator	Same day
4.6	Record all workplace injuries and illnesses on the **OSHA 300 Log**, **OSHA 300A Summary**, and **OSHA 301 Incident Report** as required.	Town Administrator	Ongoing
4.7	Maintain records for **five years** and post the OSHA 300A Summary annually (Feb 1–Apr 30).	Town Administrator	Annually

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5 Review and Follow-Up

Responsible: Town Administrator, Selectboard, Department Head

Step	Action	Responsible Party	Timeline
5.1	Review injury reports for completeness and accuracy.	Town Administrator / Selectboard	Within 7 days
5.2	Identify root causes and corrective actions.	Department Head / Selectboard	Within 14 days
5.3	Track completion of corrective actions.	Department Head	Ongoing
5.4	Retain all documentation for 3 years (town policy) and OSHA logs for 5 years.	Town Administrator	Ongoing

Town of Georgia – Supervisor Injury/Incident Checklist

This checklist must be completed by the supervisor following any employee injury or work-related incident, in compliance with the Town's Injury Reporting, Medical Treatment & Incident Review Policy and OSHA/VOSHA requirements.

■	Task	Completed (✔)
	Ensure immediate medical attention is provided to the injured employee.	
	Secure the incident area and prevent further hazards.	
	Collect witness statements and photographs (if applicable).	
	Provide Employee Injury/Incident Report form to employee.	
	Assist employee in completing form within 24 hours.	
	Obtain Work Capability Form (Form 20 or equivalent) from healthcare provider.	
	Submit full packet (forms, photos, medical info) to Town Administrator within 24 hours.	
	Confirm claim filed with PACIF (VLCT).	
	Determine if OSHA/VOSHA reporting applies:	
	• Fatality → Report within 8 hours	
	• In-patient hospitalization, amputation, or eye loss → Report within 24 hours	
	If required, contact OSHA/VOSHA via phone (1-800-321-6742) or online at www.osha.gov/report.	
	Confirm injury logged on OSHA 300/301 as applicable.	
	Participate in incident review meeting with Department Head/Town Administrator.	
	Verify corrective actions are implemented and documented.	
	File and retain copies in department records.	

Supervisor Signature: _____

Date: _____

Quick Reference – OSHA/VOSHA Reporting Requirements

Supervisors must immediately notify the Town Administrator of any incident that may meet OSHA/VOSHA reporting thresholds. The Administrator is responsible for submitting required reports to OSHA or VOSHA.

Type of Event	Reporting Timeline	Who Reports	How to Report
Fatality	Within 8 hours of learning of the death	Town Administrator	Call 1-800-321-6742 or report at www.osha.gov/
In-patient Hospitalization	Within 24 hours	Town Administrator	Same as above
Amputation	Within 24 hours	Town Administrator	Same as above
Loss of an Eye	Within 24 hours	Town Administrator	Same as above

All workplace injuries and illnesses must also be recorded on the OSHA 300 Log, OSHA 300A Summary, and OSHA 301 Incident Report as applicable. Logs must be retained for 5 years and posted annually (Feb 1 – Apr 30).

[Municipality Name]
Employee Injury Report and Supervisory Incident Review Form

Important: This form must be completed by the injured employee and his/her supervisor as soon as possible after an injury—in no case later than 24 hours after. The information may be used by the municipality to file a workers' compensation claim and enhance injury prevention efforts.

Indicate Expected Incident Type First Aid☐ Med Only☐ Med with Lost Time☐	Department:		Report Completed Date:
Exact Location of Incident:	Date of Incident:	Time of Incident: a.m./p.m.	Date Reported:

Work-Related Injury or Illness	**Tools and Safety Equipment**	**Other Information**
Injured Worker's Name:	Was a Machine or Tool Involved? Yes ☐ No ☐	List any witnesses below. Interview each witness individually. Signed witness statements should be maintained separately. 1. 2. 3.
Part of Body: RT/LT	If yes, was machine or tool defective? Yes ☐ No ☐	
Describe Injury/Illness:	Safety Equip/PPE Required? Yes ☐ No ☐ If Yes, was it used?: Yes ☐ No ☐	
Presently, is any loss of work time expected? Yes ☐ No ☐	Was there anything the injured worker could have done to prevent the injury?	**Indicate Shift Start Time on Date of Injury**:
Job Title:		

Was **First Aid** provided? Yes ☐ No ☐ If YES, by whom:

Was **Medical Treatment** provided by a healthcare provider? Yes ☐ No ☐
Check ☐ if from *[LIST YOUR MED PROVIDER HERE]*. IF other medical provider was used, name and location of provider are:

Describe details leading up to and including the accident/injury or manifestation of symptoms:

What conditions, circumstances, or factors contributed to this incident (e.g. tools, equipment, PPE, policies, object, training, hazards, employee action/inaction, weight of item, etc.)? Be thorough and descriptive!

Correction suggestions: what could be done to prevent this from happening again? ("Being more careful" is not enough.)

Who is responsible for reviewing/implementing corrective actions noted above?

Signature of Reviewing Supervisor:		Date:	
Employee Signature:		Date:	

*By the signing this form, both the injured worker and the reviewing supervisor attest that the facts and information provided here are accurate and truthful insofar as can be determined. NOTE: Self-administered first aid incidents do not require a supervisor's review, though **the employee's signature IS required** and the form must be submitted to administration for loss prevention purposes.*

VERMONT

www.labor.vermont.gov

State of Vermont
Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 20 Rev. 12/10

State File No.**: _____
Ins. Co. File No.: _____
Date of Injury: _____

Work Capabilities Form

Form recommended for use by medical providers in assessing work capabilities of patients with work injuries

Employee's Name: _____ Based on my examination of this patient on: _____

☐ May **Return to Work** with **NO RESTRICTIONS**
☐ May **Return to Work** on _____ with the following capabilities:

Stand/Walk:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Sit:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Drive:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Lift:
☐Not at all
☐No more than **10** lbs. ☐Occasionally ☐Frequently
☐No more than **20** lbs. ☐Occasionally ☐Frequently
☐No more than **50** lbs ☐Occasionally ☐Frequently
☐No more than **100** lbs. ☐Occasionally ☐Frequently
☐Unrestricted

Bend:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Squat:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Climb:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Twist:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Reach above shoulders:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Specific work capabilities not listed above: _____

Employee has limited use of: _____

Employee ☐can ☐cannot perform repetitive activities for more than _____ min/hrs.

Employee ☐can ☐cannot work more than 8 hours a day.
Work capabilities are in effect until: _____ ; or ☐until further evaluation.

☐ May **NOT RETURN TO WORK** Estimated duration of total disability: _____

Scheduled for a follow-up appointment on: _____

Referred to: _____ for follow-up care.

_____ _____
Medical Provider's Name (Print) Date

_____
Medical Providers Signature

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this medical provider to release any information acquired in the course of my examination or treatment for the above injury to my employer or its representative.

Patient Signature: _____ Date: _____

** If you do not have the state file number please contact the Department of Labor at (802) 828-2286.