GEORGIA
VERMONT

Injury Reporting, Medical Treatment & Incident Review Policy

Adopted xxxx, 2026

TABLE OF CONTENTS

1.0 REPORTING REQUIREMENTS

1.1 All injuries to employees that ~~will require be treated with first aid or actual~~ medical treatment ~~(from a healthcare provider)~~ shall be reported to the ~~supervisor/D~~department ~~H~~head or other designated person immediately or as soon as practical – and in all cases no later than the end of the shift or call.

1.2 The employee and ~~supervisor/D~~department ~~H~~head will discuss and determine the need for first aid and/or medical treatment unless the need for treatment is obvious. This is intended to keep the ~~supervisor/D~~department ~~H~~head informed about the need for treatment so ~~he/she~~they can assist in coordinating medical care and gather required information for workers' compensation reporting purposes.

1.3 These initial injury/illness reports may be provided in writing, in person, by phone, by two-way radio, or by other appropriate means.

1.4 The employee shall participate and cooperate with the ~~supervisor/D~~department ~~h~~Head or designee in the review of the injury/incident as described in section ~~3c (below).~~

1.5 If an employee voluntarily delays medical treatment or first aid for a work-related injury until sometime after the injury (including hours or days later), the employee shall promptly notify ~~his/her~~they ~~immediate supervisor/D~~department ~~H~~head as soon as ~~he/she~~they decides to apply first aid or seek medical treatment, and obtain medical treatment as outlined in section ~~2 b (below).~~

1.6 If an employee refuses initial medical treatment, but at later time independently obtains treatment on ~~his/her~~their own using ~~his/her~~their own medical provider, ~~theyhe/she~~ must notify the D~~d~~epartment ~~H~~head ~~or supervisor~~ at the first possible opportunity that medical treatment has been obtained. This will result in a referral to the designated medical provider identified in section ~~2 b (below)~~.

1.7 If the employee has been kept out of work for medical reasons due to the work-related injury, ~~he/she~~ theyshall report the expected absence as required by ~~T~~town of Georgia Personnel ~~p~~Policy and provide written documentation from the treating

medical provider indicating that the employee has been directed to remain out of work.

2.0 MEDICAL TREATMENT

2.1 In cases where emergency medical treatment is required, the local ambulance,~~/ems~~EMS ~~(~~or 911~~)~~ shall be called, and the injured employee shall be taken to the appropriate emergency medical facility determined by ~~ems~~emergency personnel.

2.2 When non-emergency treatment is required outside of the designated medical provider's office hours, employees shall use ~~either~~ the NMC walk-in clinic located at 927 Ethan Allen highway in Georgia, the~~. If~~ NMC walk-in clinic ~~is closed, please seek treatment at NMC~~ in St. Albans, or any other walk-in clinic that is convenient for the injured employee.

2.3 In situations where an employee desires to see an alternate medical provider, ~~he/she~~ they may do so after receiving the initial care as listed in this policy. A F~~f~~orm 8 ~~(~~of the Vermont W~~w~~orkers' C~~c~~ompensation division~~)~~ must be used.

2.4 In all cases where medical treatment is obtained from a healthcare provider, the employee shall receive from the medical provider a completed work capability form to document the employee's current work abilities and any restrictions. An acceptable form is the Vermont D~~d~~epartment of L~~l~~abor F~~f~~orm 20, or an equivalent that may be used by the healthcare provider. The D~~d~~epartment H~~h~~ead ~~or supervisor~~ will provide a copy of an appropriate form to the employee upon request.

3.0 INCIDENT REVIEW PROCEDURES

3.1 Upon receiving notice of a work-related injury as described above, the D~~d~~epartment H~~h~~ead ~~or supervisor~~ shall complete an E~~e~~mployee I~~i~~njury R~~r~~eport and I~~i~~ncident R~~r~~eview F~~f~~orm ("injury/incident form") with the injured employee. See example, Addendum A. Paper copies of this form will be provided to all D~~d~~epartments, and it may also be available online. ~~Https://www.vlct.org/resource/injury-reporting-medical-treatment-and-incident-review-toolkit.~~

3.2 The purpose of this form is to gather facts about the incident, when it happened, its cause(s), any witnesses, and any additional pertinent information~~etc~~. This information will be used first for filing a W~~w~~orkers' C~~c~~ompensation claim with PACIF and later to identify ways to prevent future injuries due to similar incidents.

3.3 Care shall be taken to avoid discipline-related issues during the incident review discussion between the D~~d~~epartment ~~h~~Head ~~or supervisor~~ and the injured

employee. Any warnings or other disciplinary actions shall take place separately from the incident review process.

3.4 Both the Ddepartment Hhead ~~or supervisor~~ and the injured employee shall sign the injury/incident form and attest to its accuracy.

3.5 The Ddepartment ~~h~~Head ~~or supervisor~~ and the injured employee shall complete the injury/incident form immediately if possible, but typically within 24 hours from the time of the initial incident. If extenuating medical circumstances prevent the employee from participating, the Ddepartment Hh~~h~~ead shall complete the form as soon as possible, using any and all information and assistance available.

3.6 It is important that (a) the claim be filed immediately, (b) only designated person(s) file the claim, and (c) the claim be filed with PACIF, and ~~(~~not the state of Vermont~~)~~.

3.7 All completed employee injury report and incident review forms shall be retained by the ~~municipality~~ Town of Georgia and reviewed by the T~~t~~own A~~a~~dministrator and the S~~s~~electboard for completeness and monitoring of corrective actions if any were suggested.

4.0 POLICY REVIEW

The Town of Georgia Selectboard will review the Town of Georgia Injury Reporting, Medical Treatment & Incident Review Policy as needed and will update it as required.

Adopted by the Selectboard on May 11, 2026.

_____ Kellie Bosenberg, Chair

_____ Brian Dunsmore, Vice Chair

_____ Tammy Hardy, Selectboard Member

_____ Judith Nasca, Selectboard Member

_____ Carl Rosenquist, Selectboard Member

Town of Georgia
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.
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 ☐	1. 2. 3.
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 ***NMC Urgent Care - Georgia*** 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:	