CITY OF DUBLIN
ADMINISTRATIVE ORDERS
OF THE CITY MANAGER

ADMINISTRATIVE ORDER 3.3
TO: All City of Dublin Employees
FROM: Megan D. O'Callaghan, City Manager Megan O'Callaghan
SUBJECT: Accident/Injury Reports/Exposure Records
DATE: May 1, 2025
Supersedes and replaces Administrative Order 3.3, dated February 11, 2014, regarding same subject.
PROPONENT: Division of Human Resources (Risk Management)

1. PURPOSE

The purpose of this Administrative Order is to establish procedures regarding the completion and maintenance of accident, injury, illness, and exposure records. This Administrative Order shall be applicable to all City of Dublin employees and all Department/Division Heads and supervisory personnel shall be responsible for ensuring compliance with the reporting and record keeping procedures contained herein.

2. REPORTING/RECORD KEEPING PROCEDURES/REQUIREMENTS

The following record keeping procedures/requirements are hereby established. These procedures/requirements shall be reviewed annually by the Risk Manager to ensure the City's procedures/requirements are in compliance with any revisions to the safety standards governed by Chapter 4167 of the Ohio Revised Code or of Chapter 1347 of the Ohio Revised Code.

A. Injury Investigation Reporting Procedure

(1) Supervisors will be responsible for investigating work-related accidents and illnesses and reporting them to the Risk Manager using the online incident reporting software.

(2) When an employee encounters a work-related injury, the incident must be reported on the online incident reporting software. This incident should be reported as soon as possible after an accident has been incurred, however, in no case must it be submitted later than three (3) calendar days following the date of injury.

(3) The incident should be reported on the online incident reporting software by the affected employee or their direct supervisor. Human Resources will receive notification of the report and reach out to the supervisor to complete the supervisory portion of the incident report.

(4) In the event professional medical treatment is sought for the injury/illness, the employee must obtain a work-related injury reporting packet from their supervisor and present it to the medical professional confirming that the injury is work-related. The employee must also complete a Bureau of Workers' Compensation Form FROI-1 (copy attached). Copies of these forms are usually available at the medical facility. If, however, said form is not available, one may be obtained from the Division of Human Resources or DubNet.

(5) All injuries should be reported to the employee's supervisor immediately, but in no case later than 3 calendar days following the date of injury. Failure to report an injury may preclude approval of a claim by the City of Dublin and/or the Bureau of Workers' Compensation, and may result in disciplinary action against the employee for failure to comply with the reporting procedures.

(6) All lost time for full-time personnel due to a work-related injury must also be reported through the time keeping system and a BWC Medco-14 form or supporting documentation from a licensed physician justifying that the employee is unable to return to full work status due to the illness or injury.

(7) All incidents should be reported electronically through the online incident reporting software. This software program shall be used to create the OSHA 300 log/PERRP 300AP log and the OSHA 300A/PERRP A log. In addition, managers shall utilize this database upon request from Risk Management, lost time reports and other informational graphs necessary for the review and management of injury related issues.

B. **Log and Summary of Occupational Injuries and Illnesses (OSHA Form 300/PERRP 300AP)**

The Risk Manager or other designated employee shall have the following responsibilities concerning the maintenance of the annual log and summary of recordable occupational injuries and illnesses:

(1) Maintain a log and summary of all recordable occupational injuries and illnesses by calendar year;

(2) Utilize PERRP 300P and enter information onto the log within six (6) working days after receipt of information that a recordable event has occurred.

C. **Annual Summary**

The Risk Manager, or other designated employee shall be responsible for completing and posting the attached annual summary of occupational injuries and illness by February 1 of each calendar year. This summary must remain posted until April 30th. This summary will consist of the annual totals from the PERRP 300P and will include the following:

(1) Calendar year covered;

(2) Name and address of employer;

(3) Certification signature, title, and date.

D. **General Records Maintenance**

The records mentioned above must be filed separately and maintained for each calendar year.

E. **Records Retention Schedule**

Document	Retention Period
Log and summary of all recordable occupational injuries and illnesses (PERRP 300AP).	Retained for five (5) years
Accident reports/supplementary records for each illness or injury	Retained for ten (10) years
Employee exposure records, as described in 29 CFR 1910.20 (Access to Records Policy).	Retained for thirty (30) years
Employee medical records	Retained for seventy (70) years
Employee exposure to blood borne pathogen records as described in 29 CFR 1910.1030.	Permanent
Noise exposure records.	Retained for thirty (30) years
Audiometric test records as described in 29 CFR 1910.195.	Retained for twenty (20) years

Records other than those listed above, e.g., health insurance records, etc., have no OSHA retention schedule; however, they remain subject to retention under Section 149.42 of the Ohio Revised Code.

F. **Records Destruction**

Although the above records may have reached a date on which they can be purged, Ohio Law, per chapter 149, dictates that appropriate authorization be received before any public record can be destroyed.

Attachment: FROI-1 Form

Bureau of Workers' Compensation

First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215
Note: If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

Injured worker information

First name, middle initial, last name	Date of injury/disease	Social Security number	Date of birth

Mailing address; add apartment number or P.O. Box, if applicable	City	State	ZIP code

Sex ☐ Male ☐ Female	Email address	Home phone number	Cell phone number

Employer name	Employer address	City	State	ZIP code

Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency	Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	Regular work hours (include a.m. p.m.) From To

Date hired	Job title	State where hired	State where supervised	Wage rate; $ per hour	Number of hours scheduled to work the week of this injury

Work number for call-offs (Number injured worker calls to reach supervisor)	Part(s) of body affected (For example: Left knee, right index finger)

Accident description (Describe the sequence of events that directly caused the injury or death.)	**Will the incident cause the injured worker to miss 8 or more days from work?** ☐ Yes ☐ No

Injured worker start time _____ ☐ am ☐ pm	Time of injury _____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No	Date last worked	If the injured worker has returned to work, provide the date.

Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.	Was injured worker hospitalized overnight? ☐ Yes ☐ No

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax number

Health-care office/Facility street address	City	State	ZIP code

If the injury resulted in death, answer the following.
Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

To be completed by the injured worker

By signing this form, I:

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

Furthermore, I understand that:

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.

Injured worker signature	Date

To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

Initial treatment date	Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No

Treating physician/Provider's name (Print)	Treating physician/Provider's signature	BWC provider number	Date

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.
For self-insuring employers only: ☐ Medical only ☐ Lost time
Clarification – I clarify and allow the claim for the condition(s) below.

Employer signature and title	Date

To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

Signature of person completing this form	Date