Newberg Safety Committee:
December 2011

History:

Under OSHA law the City must have an active Safety Committee to foster communication, recommend solutions, provide education and information, inspect facilities, identify hazards, review accidents, maintain records and see that compliance with OSHA and State laws are maintained. In 2002 the city Wellness Committee was merged with the Safety Committee to include wellness publications, promote healthy options and facts, provide wellness lunches, provide annual Wellness/Safety Fair, apply for and allocate funds from grants and promote the use of healthy food choices at meetings and city functions.

Meetings:

The Committee meets on the first Wednesday of every month at PSB in the main training room off the lobby. You are not required to take personal time to attend the meetings. **In your absence please send a representative from your department.** Meetings are conducted in a casual Roberts Rules format with minutes recorded in writing by a Secretary. Agenda's are to be posted in your department and minutes are to be posted after approval by the committee. At this time meetings begin at 12:30 and conclude before 2pm. For 2011-12 budget year the City Manager has approved the purchase of lunch for the committee members.

Current Positions:

Admin Liaison – **Becky Green** – 503-537-1261
Chair – **Karen Tarmichael**, Operations 503-537-1252 x0257
Grants – **Andy Willette**, NFD - 503-537-1230
Mary Newell, PSB – 503-538-1221
Pam Young, Finance – 503-554-8471
Jason Wuertz, Building - 503-537-1286
Lori Biever-Launder, Library – 503-537-7323
Nathan Anderson, PW Maint. - 503-537-1234

Committee Positions are re-assigned each January Meeting for outgoing & incoming members. Each committee member will serve in a position while on the committee. Open in January 2012 are: Secretary – Treasurer - Safety Fair - Member at Large – Wellness articles

Funding:

Grants:

Funds from grants are to be used for items listed on the grant applications and with the goal of benefiting the majority of employees. Sponsorship of sports teams and clubs that are not available to all employees are not appropriate use of funds. Likewise the purchase of supplies that benefit only a small section of the city staff is also not allowed with grant funds. Grant Funds are allocated by requesting input from all staff at the time the grant application is submitted or by having Committee representatives gain consensus from their departments about proposed projects.

City Budget Funds:

The use of funds provided under the city budget is more flexible. For example the purchase of blood pressure cuffs for Dispatch and the Library. However, all purchased equipment is to be available to all city employees regardless of the department where it is located.

Purchases:

If you are making a purchase for the City Safety Committee you must utilize your city Purchase Card or request the vendor invoice the city. Submit your invoice directly to the Committee Treasurer or the Committee Chair. Purchases should be preapproved by the committee prior to purchase. Reimbursement is not guaranteed otherwise.

Accident Reviews:

When an employee has an accident or injury it must be reported to the supervisor no matter how small. An ***incident/exposure form*** is required by the employee and supervisor. This form was updated in 2011 and distributed to all department heads. It is available on the city Intranet. IF medical attention is required the employee will fill out an 801 form with Becky Green. Safety Committee receives a copy which it reviews at the next meeting. Recommendations are made to improve safety or further fact finding is requested. The Chair informs the department head of the recommendations or questions from the committee on a form which specifies a date which response or remedies are due. For NFD minutes from NFD safety committee are provided to the Chair and Becky Green each month prior to the regularly scheduled City Safety Comm. Meetings. This internal report contains notes comments and facts about any injuries or near -miss events that occurred at NFD the month previous.

Safety Inspections:

Each quarter, pairs of committee members visit city owned work sites and conduct safety inspections using the form provided. As a courtesy please provide 24 hours notice to the supervisor at the location you will be inspecting. The inspection form is signed by a supervisor at the end of the inspection – they retain a copy, original to Becky Green and a copy to the Safety Chair. The department has 30days to respond to concerns in writing. The Chair follows up if no response is made within 30 days.

Fire Department Inspections:

As of Oct 2010 the Fire Department conducts their safety inspections. This has been approved because OSHA requires Fire Departments to inspect their facilities monthly. A copy of that report from NFD is provided to the Chair and Becky Green each month. *As a courtesy new committee members will be given a tour of both stations to be familiar with the property in the event of an incident review.*

Requests from City Staff:

Any employee of the city may make a wellness request or express a safety concern to the Safety Committee. They may direct the item to the Safety Committee representative for their department or directly to the Admin Representative or Chair. It is strongly recommended that safety concerns first be brought to the attention of the supervisor for that work area but there is no restriction on contacting the committee with a request or concern. IF you as the representative have an item brought forward by a coworker, be sure to bring that item to the attention of the committee at the next meeting or contact the Admin Liaison or Chair immediately if the issue needs urgent address.

Safety Committee Budget outline

2012 CIS Wellness Best Practice Grant :

Application due December 2011 – Fund potential $1000-1800
Previous projects under grant included:

Chair massage	$1080- 108 $10/employee
Commuter challenge organized By Jessica Nunley	$100
April - Wellness & Safety fair	$500
Door prizes for fair	$200
Healthy cooking demo CPRD, PCC, Hospital	$150
Exercise equipment for various depts.	$500

Primary Committee Budget: $2065.00

April renewal each year Monthly Wellness Council of America Magazine Subscription	$210.00
Fall Wellness Lunch – Topic and catering	$300.00
December Annual Committee Meeting & Luncheon	$200.00
Committee Lunches	$550.00
Annual Employee Frisbee Golf Door Prizes organized by Barton Brierley	$ 25.00

Risk Management Grant via CIS

This grant allows reimbursement for risk reduction purchases
Preapproved in January 2010

Completed:
- Animal Shelter Retractable hose reel
- High Visibility Safety Vests for City Hall, Library and PSB
- Nolan Ergonomic Helmets for NPD
- AED for City Hall
- Stair Railings for Library

Pending:
- Animal Shelter – Latches, anti-slip flooring – pending new bldg.

2012 Inspection Schedule

January 2011
Animal Shelter, P.W. Yard – Becky & Jason
Wastewater Treatment and Water plants – Mary & Lori
Library and Annex – Pam & Andy
City Hall, Archive Bldg, PSB – Karen & Nathan
NFD – Alex Haven

April 2011
Animal Shelter and P.W. Yard – Karen & Pam
Wastewater Treatment and Water plants – Becky & Nathan
Library and Annex – Lori & Andy
City Hall, Archive Bldg PSB– Jason & Mary
NFD – Alex Haven

July 2011
Animal Shelter and P.W. Yard –.Lori & Nathan
Wastewater Treatment and Water plants – Karen & Andy
Library and Annex Bldg – Jason & Mary
City Hall, Archive Bldg, PSB – Becky & Pam
NFD – Alex Haven

October 2011
PSB, Animal Shelter and P.W. Yard – Andy & Mary
Wastewater Treatment and Water plants – Jason & Pam
Library and Annex Bldg – Karen & Becky
City Hall, PSB, Archive Annex – Nathan & Lori
NFD – Alex Haven

Remember to give the department you are inspecting 24 hours notice or more.

If you are unable to complete an inspection

If you need to make arrangements to switch with another member notify the Chair and Secretary.

City of Newberg

Loss Prevention Program
Safety and Wellness
Management Statement

The City of Newberg holds in high regard the safety, welfare and health of our employees. Every reasonable effort shall be made to maintain a safe working environment. No job will be considered so important and no order so urgent that we cannot take time to perform our work safely.

We will establish and require a loss prevention program that emphasized the integration of safety and health into each job task so that safety and job performance become inseparable. This will be accomplished through the cooperative efforts of all employees who will work together to achieve the lowest possible workplace accident rates and quality of employee health.

The Safety Manual will be used as a tool for more effective safety and claims management. A Safety Committee has been established to coordinate the safety and wellness programs and assist management staff in promoting safe working conditions. In addition the Committee shall promote health and wellness in a number of programs including resources available through benefit partners. Safety Orientation for new and transferred employees, timely and appropriate training, management/employee safety committee, an active self-inspection program, proper mechanical guards and personal protective equipment will be some of the tools used to maintain a safe work environment.

We recognize the need to provide a workplace which meets the ergonomic needs of its employees. All work sites will be evaluated for design, layout and operation using an ergonomic approach by ergonomic professionals. Employees identifying a job site needing modification or evaluation should notify their Department Supervisor.

If you have questions about our safety policy, rules or programs please contact your Department Supervisor or Safety Committee Representative. The programs will be evaluated annually to ensure its success. The HR Administrator is a permanent member of the Safety Wellness Committee as a representative of the Management team. Employees are encouraged to take advantage of the wellness programs and resources as well as participate in the Safety Committee.

By accepting mutual responsibility to operate safely, we will all contribute to the wellbeing of one another and subsequently our organization.

City Manager

11-28-11
Date

Safety Committee Calendar

January

January 4th 1230pm - Meeting NPD Training Room

Wellness Fair -Set Date & Schedule room for Fair

Employee Newsletter wellness article

February

February 1st 1230pm – Meeting NPD Training Room

Wellness Fair - Prepare vendor list, Mail letters, Research give aways,

Check Status of Wellness Grant

Discuss City Safety Budget – submit as needed

March

March 7th 1230pm – Meeting NPD Training Room

Distribute Fair tasks among committee members, purchase giveaways Renew Wellness Council Newsletters

Employee Newsletter wellness article

1st Quarter Inspections due

April

April 4th 1230pm – Meeting NPD Training Room

Wellness Fair final check list, layout, emails posters

May

May 2nd 1230pm – Meeting NPD Training Room

Fair Wrap up, expense review and thank you notes

Plan Employee Wellness Survey

Employee Newsletter wellness article

June

June 6th 1230pm- Meeting NPD Training Room

Review Survey

Assign Safety Manual Review – chapters

2nd Quarter Inspections Due

July

July 11 1230pm - Meeting NPD Training Room

Monthly Newsletter - reminder about heat sun safety

Plan Fall wellness or safety lunch

August

August 1 1230pm – Meeting NPD Training Room

Employee Disk Golf Tourney coordinated by Barton Brierley

September

September 5th 1230pm – Meeting NPD Training Room

Fall wellness or safety Lunch

Commuter Challenge Coordinated by Jessica Nunley

3rd Quarter Inspections Due

October

October 3rd 1230pm – Meeting NPD Training Room

Complete Review of Safety manual

Monthly Newsletter – Fire Safety

Notify Dept Heads – new committee members need to be selected.

November

November 7th 1230pm – Meeting NPD Training Room

Plan December lunch location and speaker

Prepare CIS Wellness Best Practice grant submission

December

December 5th 12noon – 2pm Annual Committee Luncheon

Chair to submit Annual Safety Committee report

4th Quarter Inspections Due

Safety Committee Agenda
Nov 2, 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of October 12 2011

Inspections:
Third Quarter Inspection assignments July – September 2011

City Hall, Archive Bldg, PSB – Becky & Caleb

Fourth Quarter Inspections: Oct – Dec 2011
Animal Shelter and P.W. Yard – Andy & Melissa
Wastewater Treatment and Water plants – Jason & Caleb
Library and Annex Bldg – Karen & Craig
City Hall, Archive Bldg, PSB – Lori & Becky
Fire Dept-NFD - Alex Haven

Old Business:
Emergency Evacuation Drill City Hall: (Andy)

Follow up from NPD on Nolan Motor Helmets

Wellness Grant: Balance $900.00
Request 2 sets TRX 90 Strength training systems @$ 120 for downtown and $240 for St 21
Request 1 weight room mat 4x6 NPD $150

New Business:
Proposed OSHA Regulation changes

Incident Reports:

PW Maint – Ongoing Ankle Strain

Reports or Items from Departments:

December Meeting / Annual Lunch: Karen @ "Recipe"
New members and old members should plan to attend.

CITY OF NEWBERG

Employee Work Related
INJURY / EXPOSURE REPORT

COPY

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND RETURN TO ***NAME OF DEPT/TITLE OF RESPONSIBLE INDIVIDUAL*** WITHIN 24 HOURS FROM THE TIME OF INJURY.

Employee Name: _____ Location: City of Newberg
Job Title: Laborer I Date of Hire: _____
Date of Injury/Exposure: Past year Time of Injury / Exposure _____
Date Reported: 10-20-2011 To Whom Reported: Mike Conway
Dates of Work Lost: None Supervisor: Same
Accident /Incident Location: work place 801 Claim Form Filed? Y ( ) N (X)
Complete if medical treatment sought or time lost from work
Hours on Shift 8 Conditions at Location

Parts of Body Affected

Head/Neck	Left Side	Right Side
( ) Scalp	( )	( )
( ) Neck	( )	( )
( ) Ears	( )	( )
( ) Eyes	( )	( )
( ) Mouth	( )	( )
( ) Teeth	( )	( )
( ) Face	( )	( )

Upper Extremities	Left Side	Right Side
( ) Shoulder	( )	( )
( ) Upper Arm	( )	( )
( ) Elbow	( )	( )
( ) Forearm	( )	( )
( ) Wrist	( )	( )
( ) Hand	( )	( )
( ) Fingers	( )	( )

Lower Extremities	Left Side	Right Side
( ) Thigh	( )	( )
( ) Lower Leg	( )	( )
( ) Knee	( )	( )
x) Ankle	(x)	( )
( ) Foot/Toes	( )	( )

Trunk	Left Side	Right Side
( )Lower Back	( )	( )
( ) Upper Back	( )	( )
( )Chest	( )	( )
( ) Abdo men	( )	( )
( ) Hip	( )	( )
( ) Groin	( )	( )

Names of Witnesses: (Please provide witness information on a separate sheet of paper)

_____
_____
_____
_____

Nature of Injury

( ) Cut
( ) Scrape
( ) Bruise
( ) Skin Rash
( ) Numbness
( ) Inflammation
( ) Jammed Finger or Toe
( ) Foreign Body in Eye or Sliver
( ) Burn
( ) Electric Shock
( ) Difficulty Breathing
x) Pain in Body Part Identified at Left
( ) Dizziness
( ) Other: _____

Contributing Factors

( ) Machinery Defect (Save defective parts & pieces)
( ) Tool or Equipment Broke (Save broken parts & pieces)
( ) Equipment Guarding
( ) Proper Tools/Equipment Not Available
( ) Floor, Work Surface, or Walking Surface
( ) Housekeeping
( ) Lighting
( ) Clothing or Jewelry
( ) Improper Ergonomics
(x) Other: Every day duties

Work Behavior At Time of Injury

(Please check all items that pertain)
(x) Lifting
(x) Carrying
(x) Reaching
(x) Pushing
(x) Pulling
(x) Bending or Twisting (circle correct item)
( ) Running
(x) Stepping (walking/ moving from one level to another)
( ) Typing / Office Related Repetitive Motion
(x) Other Repetitive Motion Tasks
( ) Jumping
( ) Driving (If so, what vehicle?)
(x) Operating Equipment
( ) Innocent Bystander
( ) Other _____

Distribution of Copies:
Original: Risk Manager within 24 hours | 1 copy to Employee | 1 copy: Supervisor/Dept. Head

Was Safety Equipment/ Personal Protective Equipment In Use At Time of Injury /Exposure: Yes No

Type SE OR PPE In Use: _____

Describe what happened (include sequence of events; equipment, materials, and substances being used; and environment — PLEASE BE SPECIFIC):

The past three months I've been working my new job description, in doing so, my ankle joint has been slowly deteriorating. It has become very painful on the inner side of my ankle joint.

How long have you been doing this particular job?: I have been doing this job about one year

Have there been similar incidents/near misses in the past? ___ No _X_ YES

Describe history or similar incidents: Injured same ankle and had surgery June 2010

What do you think can be done to prevent this incident from reoccurring?

I believe this is a direct result of my previous injury to the same ankle. At this time I do not intend to see a doctor unless my condition worsens. Leaving my employment is not an option.

To Be Completed By Employee's Supervisor:

Why did the Injury/Exposure happen or the condition exist?

What should be done, to prevent this Injury/Exposure:

Employee's Signature: _____ Date: 10-21-11

Supervisor's Signature: Mike Conway Jr Date: 10-24-11

Risk Manager's Signature: _____ Date: _____

SAFETY COMMITTEE EVALUATION OF INJURY / EXPOSURE

Committee Recommendations/Corrective Action

Corrective Action Assigned To _____

Date corrections shall be implemented: _____

Safety Committee Agenda
October 12, 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of September 2011

Inspections:
Third Quarter Inspection assignments July – September 2011

Animal Shelter and P.W. Yard –.Lori & Craig (completed)
Wastewater Treatment and Water plants –Karen & Andy/Justin (completed)
Library and Annex Bldg – Jason & Melissa
City Hall, Archive Bldg, PSB – Becky & Caleb
Fire Dept-NFD Alex Haven (completed)

Basic Housekeeping and proper overflow storage continues to be an issue at several sites.

Fourth Quarter Inspections: Oct – Dec 2011

Animal Shelter and P.W. Yard – Andy & Melissa
Wastewater Treatment and Water plants – Jason & Caleb
Library and Annex Bldg – Karen & Craig
City Hall, Archive Bldg, PSB – Lori & Becky
Fire Dept-NFD - Alex Haven

Old Business:
Karen -CIS Wellness Seminar wrap up – free resources.

City Hall –
Phone Paging
Training request to Dept Heads.

Risk Mngmt Grant Projects: Status
Update Animal Shelter improvements:

Wellness Grant:
NFD requesting TRX Strength training bands
Balance of CIS Wellness Grant is @ $945.00
How do we want to use balance of Wellness Grant ? (ei Fall Wellness lunch – purchases - other?)

New Business:
Status - City Hall Emerg Evac drill
Who will Coordinate with NFD Chris Mayfield ?
Wellness Newsletter – first issue out. How often and who will produce.

Incident Reports:
NPD – Muscle Strains x2 same incident NPD – Blood Exposure
NFD – Knee Injury/Strain
PW OPS – Head Laceration

Reports or Items from Departments:

November Lunch Coordinator: Becky
December Meeting / Annual Lunch: Karen – proposing "Recipe" as location
New members and old members should plan to attend.

CITY OF NEWBERG

Employee Work Related
INJURY / EXPOSURE REPORT

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND RETURN TO ***NAME OF DEPT/TITLE OF RESPONSIBLE INDIVIDUAL*** WITHIN 24 HOURS FROM THE TIME OF INJURY.

Employee Name: _____ Location: _____
Job Title: _____ Date of Hire: _____
Date of Injury/Exposure: _____ Time of Injury / Exposure _____
Date Reported: _____ To Whom Reported: _____
Dates of Work Lost: _____ Supervisor: _____
Accident /Incident Location: _____ 801 Claim Form Filed? Y ( ) N ( )
Complete if medical treatment sought or time lost from work

Hours on Shift Conditions at Location

Parts of Body Affected

Head/Neck	Left Side	Right Side
( ) Scalp	( )	( )
( ) Neck	( )	( )
( ) Ears	( )	( )
( ) Eyes	( )	( )
( ) Mouth	( )	( )
( ) Teeth	( )	( )
( ) Face	( )	( )

Upper Extremities	Left Side	Right Side
( ) Shoulder	( )	( )
( ) Upper Arm	( )	( )
( ) Elbow	( )	( )
( ) Forearm	( )	( )
( ) Wrist	( )	( )
( ) Hand	( )	( )
( ) Fingers	( )	( )

Lower Extremities	Left Side	Right Side
( ) Thigh	( )	( )
( ) Lower Leg	( )	( )
( ) Knee	( )	( )
( ) Ankle	( )	( )
( ) Foot/Toes	( )	( )

Trunk	Left Side	Right Side
( )Lower Back	( )	( )
( ) Upper Back	( )	( )
( )Chest	( )	( )
( ) Abdo men	( )	( )
( ) Hip	( )	( )
( ) Groin	( )	( )

Names of Witnesses: (Please provide witness information on a separate sheet of paper)

_____
_____
_____
_____

Nature of Injury

( ) Cut
( ) Scrape
( ) Bruise
( ) Skin Rash
( ) Numbness
( ) Inflammation
( ) Jammed Finger or Toe
( ) Foreign Body in Eye or Sliver
( ) Burn
( ) Electric Shock
( ) Difficulty Breathing
( ) Pain in Body Part Identified at Left
( ) Dizziness
( ) Other: _____

Contributing Factors

( ) Machinery Defect (Save defective parts & pieces)
( ) Tool or Equipment Broke (Save broken parts & pieces)
( ) Equipment Guarding
( ) Proper Tools/Equipment Not Available
( ) Floor, Work Surface, or Walking Surface
( ) Housekeeping
( ) Lighting
( ) Clothing or Jewelry
( ) Improper Ergonomics
( ) Other: _____

Work Behavior At Time of Injury

(Please check all items that pertain)
( ) Lifting
( ) Carrying
( ) Reaching
( ) Pushing
( ) Pulling
( ) Bending or Twisting (circle correct item)
( ) Running
( ) Stepping (walking/ moving from one level to another)
( ) Typing / Office Related Repetitive Motion
( ) Other Repetitive Motion Tasks
( ) Jumping
( ) Driving (If so, what vehicle?)
( ) Operating Equipment
( ) Innocent Bystander
( ) Other _____

Distribution of Copies:
Original: Risk Manager within 24 hours | 1 copy to Employee | 1 copy: Supervisor/Dept. Head

CITY OF NEWBERG

Employee Work Related
INJURY / EXPOSURE REPORT

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Job Title: _____ Date of Hire: _____
Date of Injury/Exposure: _____ Time of Injury / Exposure _____
Date Reported: _____ To Whom Reported: _____
Dates of Work Lost: _____ Supervisor: _____
Accident /Incident Location: _____ 801 Claim Form Filed? Y ( ) N ( )
Complete if medical treatment sought or time lost from work
Hours on Shift Conditions at Location

Parts of Body Affected

Head/Neck	Left Side	Right Side
( ) Scalp	( )	( )
( ) Neck	( )	( )
( ) Ears	( )	( )
( ) Eyes	( )	( )
( ) Mouth	( )	( )
( ) Teeth	( )	( )
( ) Face	( )	( )

Upper Extremities	Left Side	Right Side
( ) Shoulder	( )	( )
( ) Upper Arm	( )	( )
( ) Elbow	( )	( )
( ) Forearm	( )	( )
( ) Wrist	( )	( )
( ) Hand	( )	( )
( ) Fingers	( )	( )

Lower Extremities	Left Side	Right Side
( ) Thigh	( )	( )
( ) Lower Leg	( )	( )
( ) Knee	( )	( )
( ) Ankle	( )	( )
( ) Foot/Toes	( )	( )

Trunk	Left Side	Right Side
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( ) Groin	( )	( )

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( ) Burn
( ) Electric Shock
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( ) Pain in Body Part Identified at Left
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( ) Other: _____

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( ) Equipment Guarding
( ) Proper Tools/Equipment Not Available
( ) Floor, Work Surface, or Walking Surface
( ) Housekeeping
( ) Lighting
( ) Clothing or Jewelry
( ) Improper Ergonomics
( ) Other: _____

Work Behavior At Time of Injury

(Please check all items that pertain)
( ) Lifting
( ) Carrying
( ) Reaching
( ) Pushing
( ) Pulling
( ) Bending or Twisting (circle correct item)
( ) Running
( ) Stepping (walking/ moving from one level to another)
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( ) Other Repetitive Motion Tasks
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( ) Other _____

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Original: Risk Manager within 24 hours | 1 copy to Employee | 1 copy: Supervisor/Dept. Head

Was Safety Equipment/ Personal Protective Equipment In Use At Time of Injury /Exposure: Yes No

Type SE OR PPE In Use: _____

Describe what happened (include sequence of events; equipment, materials, and substances being used; and environment — PLEASE BE SPECIFIC):

How long have you been doing this particular job?: _____

Have there been similar incidents/near misses in the past? ___ No ____ YES

Describe history or similar incidents:

What do you think can be done to prevent this incident from reoccurring?

To Be Completed By Employee's Supervisor:

Why did the Injury/Exposure happen or the condition exist?

What should be done, to prevent this Injury/Exposure:

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Risk Manager's Signature: _____ Date: _____

SAFETY COMMITTEE EVALUATION OF INJURY / EXPOSURE

Committee Recommendations/Corrective Action

Corrective Action Assigned To _____

Date corrections shall be implemented: _____

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, m: | TITLE: Maint Mechanic

1. Date of injury or illness: 9-27-11
2. Date you left work: NA
3. Shift on day of injury: 6 (from) ☒ a.m. ☐ p.m. 4:30 (to) ☐ a.m. ☐ p.m.
4. Regularly scheduled days off: ☒ M ☐ T ☐ W ☐ T ☐ F ☒ S ☒ S
5. Time of injury or illness: 11:30 ☒ a.m. ☐ p.m.
6. Time you left work: 11:30 ☒ a.m. ☐ p.m.
7. Check here if you are employed by more than one employer: ☐

8. What is your illness or injury? What part of the body? Which side? ☐ Left ☐ Right (Example: sprained right foot) Abrasion
9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):

10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials)
I Bent over + bumped my head

11. Name of Witnesses: NA
12. Have you previously injured or sought treatment for this body part? ☒ No ☐ Yes
13. Your lega
14. [illegible] ☐ F
16. Mailing a [illegible] ect Or 97107
18. SSN: [illegible]
20. Work Phone:

21. Name of physician or health-care professional:
22. If medical treatment was given away from the worksite, print name and address of facility: 1001 Providence Dr
23. Were you hospitalized overnight as an inpatient? ☒ No ☐ Yes
24. Were you treated in the emergency room? ☐ No ☒ Yes
[redacted] ER Providence Newberg

25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature: [signature]
28. Date: 9-27-11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: City of Newberg Ops.
30: Phone: 503-537-1252
31. FEIN: 93-6002221
32. If worker leasing company List client business name:
33. Client FEIN:
34. Address of principal place of business (not P.O. box): 414 E. First St. Newberg, OR
35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 2301 Wynooski Road Newberg ZIP: 97132
37. Nature of business in which worker is/was supervised: municipal government
38. Street address, city, and State where event occurred: 2301 Wynooski Road Newberg 97132
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No
40. NCCI code: 8380
41. Were other workers injured? ☐ Yes ☒ No
42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No
43. OSHA 300 log case #:
44. Date employer knew of claim: 9/27/2011
45. Worker's weekly wage: $ 4747.1/mo
46. Date worker hired: 10/27/2005
47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☒ Regular Date: 9/27/11 ☐ Modified Date:
49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J Green
51. Name, title and phone (print): Rebecca J Green HR Manager 503537-1361
52. Date: 9/27/2011

801

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

x801 1/05

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, middle) [redacted] | JOB TITLE: Firefighter

1. Date of injury or illness: 9/21/11
2. Date you left work: NA
3. Shift on day of injury: 0730 (from) ☐ a.m. ☐ p.m. 0730 (to) ☐ a.m. ☐ p.m.
4. Regularly scheduled days off: ☒ M ☒ T ☐ W ☒ T ☒ F ☐ S ☒ S — 24 on 48 off
5. Time of injury or illness: 0900 ☒ a.m. ☐ p.m.
6. Time you left work: NA ☐ a.m. ☐ p.m.
7. Check here if you are employed by more than one employer: ☐
8. What is your illness or injury? What part of the body? Which side? ☒ Left ☐ Right (Example: sprained right foot) Knee
9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials) I was kneeling down to loosen hose and felt a sharp pair in my knee. I now have a burning/itching feeling in my knee.
11. Name of Witnesses: Shannon Hamlet
12. Have you previously injured or sought treatment for this body part? ☐ No ☒ Yes
13. Your le[illegible] ☐ F
16. Mailing [illegible]lege ST Newberg, OR 97132
18. SSN: [illegible]
19. Dept.: Fire
21. Name o[illegible] health-care professional: Providence Or med
22. If medical treatment was given away from the worksite, print name and address of facility: Providence Hospital Newberg OR 97132
23. Were you hospitalized overnight as an inpatient? ☒ No ☐ Yes
24. Were you treated in the emergency room? ☒ No ☐ Yes

25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature: [signature]
28. Date: 9/22/11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: Newberg Fire Dept
30: Phone: 503-537-1230
31. FEIN: 93-6002221
32. If worker leasing company, List client business name:
33. Client FEIN:
34. Address of principal place of business (not P.O. box): 414 E. Second St. Newberg OR.
35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 414 E Second St. Newberg OR ZIP: 97132
37. Nature of business in which worker is/was supervised: municipal government
38. Street address, city, and State where event occurred: St. 21, 2100 Middlebrook Rd. Newberg OR 97132
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No
40. NCCI code: 7710
41. Were other workers injured? ☐ Yes ☒ No
42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No
43. OSHA 300 log case #:
44. Date employer knew of claim: 9/21/11
45. Worker's ~~weekly~~ wage: monthly $ 5280.00
46. Date worker hired: 4/1/08
47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☒ Regular Date: ☐ Modified Date:
49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J. Green
51. Name, title and phone (print): REBECCA J. GREEN HR manager 503-537-1261
52. Date: 9/22/2011

801

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801

x801 1/05

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

JOB TITLE: Police Officer

1. Date of injury or illness:	2. Date you left work:	3. Shift on day of injury:	4. Regularly scheduled days off:
10/04/11	NA	7 (from) ☒ a.m. ☐ p.m. 5 (to) ☐ a.m. ☒ p.m.	☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S * Varies
5. Time of injury or illness: 8 10 ☒ a.m. ☐ p.m.	6. Time you left work: NA ☐ a.m. ☐ p.m.	7. Check here if you are employed by more than one employer: ☐	

8. What is your illness or injury? What part of the body? Which side? ☐ Left ☒ Right (Example: sprained right foot) Blood Exposure Rt Forearm

9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):

10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials) Loading and restraining a medical/suicidal patient who was covered in his own blood. I got some of his blood on my right fore arm. I have non intact skin due to scratches on this arm

11. Name of Witnesses:

12. Have you previously injured or sought treatment for this body part? ☐ Yes 2 previous exposure incidents

13

15. Gender: ☒ M ☐ F

16

18

20. Work Phone: 503 [illegible]

21. Name of physician or health-care professional:

22. If medical treatment was given away from the worksite, print name and address of facility: Newberg Occupational Health 1000 Providence Dr. Newberg OR 97132

23. Were you hospitalized overnight as an inpatient? ☒ No ☐ Yes

24. Were you treated in the emergency room? ☒ No ☐ Yes

25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature:

28. Date: 10/04/11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. **Employer legal Business name:** City of Newberg Police	30: Phone 503-538-8321	31. FEIN: 93-6002221
32. If worker leasing company, List client business name:		33. Client FEIN:
34. Address of principal place of business (not P.O. box): 401 E. Third St. Newberg OR 97132		35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 401 E. Third St. Newberg OR ZIP 97132		37. Nature of business in which worker is/was supervised: Municipal Gov.
38. Street address, city, and State where event occurred: 925 S. River St. #12, Newberg OR 97132		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No		40. NCCI code: 7720
41. Were other workers injured? ☐ Yes ☒ No	42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim: 10/4/11	45. Worker's weekly wage: $ 6192. mo	46. Date worker hired: 5/2/05
		47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☒ Regular Date: 10/4/11 ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J Green	51. Name, title and phone (print): Rebecca J Green HR Manager 503-537-1261	52. Date: 10/4/11

801

x801 1/05

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

CITY OF NEWBERG

Employee Work Related
INJURY / EXPOSURE REPORT

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND RETURN TO *NAME OF DEPT/TITLE OF RESPONSIBLE INDIVIDUAL* WITHIN 24 HOURS FROM THE TIME OF INJURY.

Employee Name: _____
Job Title: Sgt.
Date of Injury/Exposure: 9/20/11
Date Reported: 9/22/11 n/a phone
Dates of Work Lost: NA
Accident /Incident Location: 712 E 8th St

Location: 712 E. 8th St.
Date of Hire: 12/13/93
Time of Injury / Exposure 0300
To Whom Reported: Capt Bolek
Supervisor: Capt Bolek
801 Claim Form Filed? Y ( ) N ( )
Complete if medical treatment sought or time lost from work

Parts of Body Affected

Head/Neck	Left Side	Right Side
( ) Scalp	( )	( )
( ) Neck	( )	( )
( ) Ears	( )	( )
( ) Eyes	( )	( )
( ) Mouth	( )	( )
( ) Teeth	( )	( )
( ) Face	( )	( )

Upper Extremities	Left Side	Right Side
(X) Shoulder	(X)	( )
( ) Upper Arm	( )	( )
( ) Elbow	( )	( )
( ) Forearm	( )	( )
( ) Wrist	( )	( )
( ) Hand	( )	( )
( ) Fingers	( )	( )

Lower Extremities	Left Side	Right Side
( ) Thigh	( )	( )
( ) Lower Leg	( )	( )
( ) Knee	( )	( )
( ) Ankle	( )	( )
( ) Foot/Toes	( )	( )

Trunk	Left Side	Right Side
(X) Lower Back	(X)	( )
(X) Upper Back	(X)	( )
( ) Chest	( )	( )
( ) Abdo men	( )	( )
( ) Hip	( )	( )
( ) Groin	( )	( )

Nature of Injury

( ) Cut
( ) Scrape
( ) Bruise
( ) Skin Rash
( ) Numbness
( ) Inflammation
( ) Jammed Finger or Toe
( ) Foreign Body in Eye or Sliver
( ) Burn
( ) Electric Shock
( ) Difficulty Breathing
( ) Pain in Body Part Identified at Left
( ) Dizziness
(X) Other: muscle strain/pull

Contributing Factors

( ) Machinery Defect (Save defective parts & pieces)
( ) Tool or Equipment Broke (Save broken parts & pieces)
( ) Equipment Guarding
( ) Proper Tools/Equipment Not Available
( ) Floor, Work Surface, or Walking Surface
( ) Housekeeping
( ) Lighting
( ) Clothing or Jewelry
( ) Improper Ergonomics
( ) Other: _____

Work Behavior At Time of Injury

(Please check all items that pertain)
(X) Lifting
(X) Carrying
( ) Reaching
( ) Pushing
( ) Pulling
( ) Bending or Twisting (circle correct item)
( ) Running
( ) Stepping (walking/ moving from one level to another)
( ) Typing / Office Related Repetitive Motion
( ) Other Repetitive Motion Tasks
( ) Jumping
( ) Driving (If so, what vehicle?)
( ) Operating Equipment
( ) Innocent Bystander
( ) Other _____

Names of Witnesses: (Please provide witness information on a separate sheet of paper)
Paul Cooley
Nate James
Ken Howell

Medical Attn. other than massage sought @ this time. 9/27/11 (3)

Distribution of Copies:
Original: Risk Manager within 24 hours | 1 copy to Employee | 1 copy: Supervisor/Dept. Head

CITY OF NEWBERG

Employee Work Related
INJURY / EXPOSURE REPORT

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND RETURN TO *NAME OF DEPT/TITLE OF RESPONSIBLE INDIVIDUAL* WITHIN 24 HOURS FROM THE TIME OF INJURY.

Employee Name: _____
Job Title: Police Officer
Date of Injury/Exposure: 9-21-11
Date Reported: 9-28-11
Dates of Work Lost: Ø
Accident /Incident Location: 710 E 8th St Newberg OR 97132

Location: Newberg Police Dept.
Date of Hire: 10-25-99
Time of Injury / Exposure 0300 9-22-11
To Whom Reported: Sgt. Gwen Johns
Supervisor: _____
801 Claim Form Filed? Y ( ) N (X)
Complete if medical treatment sought or time lost from work

Parts of Body Affected

Head/Neck	Left Side	Right Side
( ) Scalp	( )	( )
(X) Neck	(X)	( )
( ) Ears	( )	( )
( ) Eyes	( )	( )
( ) Mouth	( )	( )
( ) Teeth	( )	( )
( ) Face	( )	( )

Upper Extremities	Left Side	Right Side
(X) Shoulder	(X)	( )
( ) Upper Arm	( )	( )
( ) Elbow	( )	( )
( ) Forearm	( )	( )
( ) Wrist	( )	( )
( ) Hand	( )	( )
( ) Fingers	( )	( )

Lower Extremities	Left Side	Right Side
( ) Thigh	( )	( )
( ) Lower Leg	( )	( )
( ) Knee	( )	( )
( ) Ankle	( )	( )
( ) Foot/Toes	( )	( )

Trunk	Left Side	Right Side
( ) Lower Back	( )	( )
( ) Upper Back	( )	( )
( ) Chest	( )	( )
( ) Abdo men	( )	( )
( ) Hip	( )	( )
( ) Groin	( )	( )

Nature of Injury

( ) Cut
( ) Scrape
( ) Bruise
( ) Skin Rash
( ) Numbness
( ) Inflammation
( ) Jammed Finger or Toe
( ) Foreign Body in Eye or Sliver
( ) Burn
( ) Electric Shock
( ) Difficulty Breathing
(X) Pain in Body Part Identified at Left
( ) Dizziness
( ) Other: _____

Contributing Factors

( ) Machinery Defect (Save defective parts & pieces)
( ) Tool or Equipment Broke (Save broken parts & pieces)
( ) Equipment Guarding
( ) Proper Tools/Equipment Not Available
( ) Floor, Work Surface, or Walking Surface
( ) Housekeeping
( ) Lighting
( ) Clothing or Jewelry
( ) Improper Ergonomics
(X) Other: Precarious Position of dead person

Work Behavior At Time of Injury

(Please check all items that pertain)
(X) Lifting
( ) Carrying
( ) Reaching
( ) Pushing
( ) Pulling
(X) Bending or Twisting (circle correct item)
( ) Running
(X) Stepping (walking/ moving from one level to another)
( ) Typing / Office Related Repetitive Motion
( ) Other Repetitive Motion Tasks
( ) Jumping
( ) Driving (If so, what vehicle?)
( ) Operating Equipment
( ) Innocent Bystander
( ) Other _____

Names of Witnesses: (Please provide witness information on a separate sheet of paper)

_____
_____
_____
_____

Medical NOT sought by time of this Report. Using Heat-wraps, Thermal Ibuprofen.

Distribution of Copies:
Original: Risk Manager within 24 hours | 1 copy to Employee | 1 copy: Supervisor/Dept. Head

Stress and Productivity:

id you know your physical health affects your ability to manage work stress and productivity? Improve your professional performance AND keep insurance costs from rising.

- Groups that take "walking" meetings around campus or town
- Managers that insist employees take BOLI required breaks away from desks,
- Organizations that encourage fitness (golf, bowling teams, walking, volunteering)

All see a 40% increase in productivity and a 35% drop in illness and injuries. That's money in the bank. A Win - Win for everyone.

The 30 / 3 rule: Take a 3 minute break

If you have been stationary / seated for 30 minutes
OR
If you have used an electronic device (computer, smart phone, MDT) for 30 minutes

The strain on your eyes, the decrease in blood circulation in your body and the compression of your spine from sitting all have long term effects on your body. There has been a marked increase in back and eye strain (CVS) in youth and adults.

Want to earn Gift Cards to your favorite stores ?

Regence Insurance members:

Check out **MYRegnece.com** and log on to the ***My Health >Rewards program***. It's an online log where you earn points for healthy choices like *brushing your teeth, walking the dog, eating lunch and even volunteering.*

When you reach 70,000 points you can choose a gift card from participating stores such ***as Cabela's, Amazon.com, CVS Pharmacy, Bath & Body Works, Olive Garden and more*** … with the holidays coming you could earn gift cards just for logging the things you do every day.

Help on Line: You have access to videos and articles on line at MyRBH.Com.

Watch short video to learn more about the work-life resources site "Personal Advantage" accessible through MyRBH.com. http://personaladvantage.com/public/reliantbh/player.html

he new site includes assessments and articles, a featured video of the week that incorporates real stories, a daily stress tip, trainings, and more wellness and work-life topics.
Contact RBH today at 1-866-750-1327, or visit www.MyRBH.com.

Safety Committee Agenda
September 7 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of August 2011

Inspections:

Third Quarter Inspection assignments
July – September 2011

Animal Shelter and P.W. Yard –.Lori & Craig (completed)
Wastewater Treatment and Water plants –Karen & Andy/Justin (completed)
Library and Annex Bldg – Jason & Melissa
City Hall, Archive Bldg, PSB – Becky & Caleb
Fire Dept-NFD Alex Haven (st 20 completed – st 21 pending 9-19-11)

Basic Housekeeping and proper overflow storage continues to be an issue at several sites.

Old Business:
Becky, Karen & Caleb are attending the free CIS Seminar on Sept 8th in Hillsboro

Risk Mngmt Grant Projects: Status
Animal Shelter improvements: Hose Reel, Anti Slip floor coating and Flat Gate latches - status
Wellness Grant:
Massage Program Status – completed all sites invoices received. Complete – 77 employees attended $770.00
Balance of CIS Wellness Grant is @ $945.00
How do we want to use balance of Wellness Grant ? (ei Fall Wellness lunch – purchases - other?)

Is there a new CIS Wellness Grant to apply for ?

New Business:
City Hall Emerg Evac drill ?

Incident Reports:
Bee Sting – PWM
Shoulder injury – NPD K9
Traffic Accident - NFD

Reports or Items from Departments:
Sodium Bisulfite leak at WWTP - Summary

October Lunch Coordinator: Melissa - Need substitute for Oct
November Lunch Coordinator: Becky
December Meeting / Annual Lunch: Karen

Adjourn

Safety Committee Agenda
August 3 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of July 2011

Inspections:

Third Quarter Inspection assignments
July – September 2011

Animal Shelter and P.W. Yard –.Lori & Craig
Wastewater Treatment and Water plants – Karen & Andy
Library and Annex Bldg – Jason & Melissa
City Hall, Archive Bldg, PSB – Becky & Caleb
Fire Dept-NFD Alex Haven

Old Business:

Inspection Forms – Revisions due

Letter to dept heads regarding Emergency procedures at City Hall

Risk Mngmt Grant Projects: Status
Animal Shelter improvements: Hose Reel, Anti Slip floor coating and Flat Gate latches
Massage Program Status

New Business:

Who is attending the CIS Seminar on Sept 8th in Hillsboro ?

Incident Reports:
PWM Welding injury
Library – Stress
NPD Puncture
PWM – Fall/Fainting

Reports or Items from Departments:

September Lunch Coordinator: Jason

Adjourn

Safety Committee Meeting Minutes
July 6, 2011 12:30 p.m.
Public Safety Building

Present:
Lori Biever-Launder (Library), Jason Wuertz (Planning/Building/Engineering), Craig Brault (PW Maintenance), Karen Tarmichael (Operations) Becky Green (Administration), Andy Willette (NFD), Caleb Lippard (Finance), Melissa Cleveland (NPD).

Review and Approval of Minutes:

MOTION#1: Brault/Biever-Launder motioned and seconded to approve the minutes from the Newberg Safety Committee of May 2011. (8 Yes/0 No).

Inspections:

- **Second Quarter Inspections:**
  P.S. Bldg, Animal Shelter, P.W. Yard – Caleb Karen (Completed)
  Wastewater Treatment and Water plants – Becky & Craig (done 4-1-11)
  Library and Annex – Lore & Andy (Completed)
  City Hall and Archives, PSB –Jason & Melissa – needs to be done.
  Fire Dept-NFD Alex Haven (Station 20 & 21 completed)

Issues of note: Cords across work areas / Cabinets not secured/ Leaking Air cylinders/unsecured tanks – issues corrected.

- **Third Quarter Inspection Assignments:**
  P.S. Bldg, Animal Shelter, P.W. Yard – Lori & Craig
  Wastewater Treatment and Water plants – Karen & Andy
  Library and Annex – Jason & Melissa
  City Hall and Archives, PSB –Becky & Caleb
  Fire Dept-NFD Alex Haven

OLD BUSINESS
Anti-slip resurfacing was done at the library.
Inspection forms/revisions due Aug. 3rd meeting.
Risk Management Grant: Karen has meeting with Clinton to talk about items at the Animal Shelter.

NEW BUSINESS
CIS Wellness Grant: Committee will proceed to schedule employee Chair Massages. Each Safety Rep will coordinate their own departments. Karen will send out Masseuse contact info. The Masseuse will only charge for each person she massages.

There is a concern of a gas smell /leak at City Hall. The smell has been intermittent for the past three weeks. Fire Dept. was notified by an employee who walked over to mention issue. The gas company came out to investigate. If the smell comes back contact Newberg Dispatch ASAP. An email will go out to all Dept. Heads to remind employees of proper Emerg. Response Procedures. Evacuation Policies are posted in City Hall Lunch Room and by copier. Also Karen will notify PWM that the access to the Nat Gas shutoff outside was over grown and needs to be cleared for access. Fire Marshall will address the access issues with the Fire Shut off systems which were also obstructed.

OSHA handouts were attached to meeting agenda. (PPE & Heat Safety) post at work sites.

Parking lines at the public lot next to the library need to be re-done. Craig will forward concern to PWM.

Incident Reports:
Knee Injury at Operations-no recommendation - No safety issue.
Leg Puncture wound at PWM- no recommendations -reminder review work areas for hazards when possible.

Meeting adjourned at 1:40 p.m.

Importance: High

Based on the responses to our "Worksite Wellness Programs on ZERO budgets" survey, we will be sponsoring two FREE wellness training sessions on Thursday September 8 featuring author and walking expert Robert Sweetgall. These sessions will be of interest to wellness committee members, HR/Benefits representatives, and anyone else at your entity that serves as a "wellness champion". Robert will focus much of his session on easy ways to promote physical activity both within your workplaces and in the personal lives of employees and their families. Our Benefits partners – Regence BCBSO and Kaiser Permanente - will also share physical activity programs & resources they provide.

Please RSVP back to healthybenefits@cisoregon.org which session your entity plans to attend, and the number of employees attending with you. **RSVP by August 3**.

- 8:30-11:30 AM, September 8: Salem Fresh Start Market Connections Center
- 1:30-4:30 PM, September 8: Hillsboro City Auditorium

These sessions promise to be fun and eventful - come prepared to MOVE. Sessions will also include Creative Walking gifts for a few lucky winners and healthy snacks for all from CIS Benefits.

You will receive a subsequent email with specific training addresses and driving directions.

- 1:30-4:30 PM, September 8: Hillsboro City Auditorium

Total number attending _____

Heather Matthews | Benefits Administrative Assistant
p 503-763-3826 | 800-922-2684 x3826 | f 503-763-3926
www.cisoregon.org

CIS adapts to meet the changing risk management and benefits needs of our members, seeing potential problems and developing solutions.

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, middle) [redacted]		JOB TITLE: Mechanic	
1. Date of injury or illness: 7-22-11	2. Date you left work: 7-22-11	3. Shift on day of injury: 8 (from) ☒ a.m. ☐ p.m. 4:30 (to) ☐ a.m. ☒ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☒ S ☒ S
5. Time of injury or illness: 11:00 ☒ a.m. ☐ p.m.	6. Time you left work: 2:00 ☐ a.m. ☒ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? ☒ Left ☐ Right (Example: sprained right foot) burned inner left ear		9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):	

10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials) welding underneath a vehicle. A hot spark landed in my left ear

11. Name of Witnesses:	12. Have you previously injured or sought treatment for this body part? ☒ No ☐ Yes	
13. Your legal name: [redacted]	14. Birthdate: [redacted]	15. Gender: ☒ M ☐ F
16. Mailing address, city, state and zip: [redacted]		17. Home Phone: [redacted]
18. SSN: [redacted]	19. Dept.: PW M	20. Work Phone: 503-537-1232
21. Name of physician or health-care professional: DR. White	22. If medical treatment was given away from the worksite, print name and address of facility: Newberg Urgent Care	
23. Were you hospitalized overnight as an inpatient? ☒ No ☐ Yes		
24. Were you treated in the emergency room? ☒ No ☐ Yes		

25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.

26. Worker Signature: [redacted]	27. Completed by (please print): [redacted]	28. Date: 7-25-11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: City of Newberg PW	30: Phone: 503-537-1234	31. FEIN: 93-6002221
32. If worker leasing company, List client business name:		33. Client FEIN:
34. Address of principal place of business (not P.O. box): 500 W. Third St. Newberg OR 97132		35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 500 W. Third St. Newberg ZIP: 97132		37. Nature of business in which worker is/was supervised: municipal government
38. Street address, city, and State where event occurred: 500 W Third St. Newberg OR 97132		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No		40. NCCI code: 8380
41. Were other workers injured? ☐ Yes ☒ No	42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim: 7/22/2011	45. Worker's weekly wage: mo. $ 4327.	46. Date worker hired: 9/16/91
47. If fatal, date of death:		
48. Return-to-work status: ☐ Not returned ☒ Regular Date: 7/25/11 ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J. Green	51. Name, title and phone (print): REBECCA J. GREEN, HR Manager 503-537-1261	52. Date: 7/25/11

801

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

x801 1/05

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, middle) [redacted]			JOB TITLE: Circulation Clerk
1. Date of injury or illness: 7/1/11	2. Date you left work: July 1 2011	3. Shift on day of injury: Noon (from) ☐ a.m. ☑ p.m. S.U (to) ☐ a.m. ☑ p.m.	4. Regularly scheduled days off: ☒ M ☐ T ☐ W ☐ T ☐ F ☒ S ☒ S
5. Time of injury or illness: 11:45 ☑ a.m. ☐ p.m.	6. Time you left work: 5:00 ☐ a.m. ☒ p.m.	7. Check here if you are employed by more than one employer: ☐	

8. What is your illness or injury? What part of the body? Which side? ☐ Left ☐ Right
(Example: sprained right foot) Anxiety

9. Workers' language preference other than English:
☐ Spanish ☐ Other (please specify):

10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials) Due to increased work load for Circulation staff I have suffered anxiety attacks.

11. Name of Witnesses: Korie Bierkle	12. Have you previously injured or sought treatment for this body part? ☒ No ☐ Yes
13. Your legal name: [redacted]	14. Birthdate: [redacted] 15. Gender: ☐ M ☒ F
16. Mailing address, city, state and zip: [redacted]	17. Home Phone: [redacted]
18. SSN: [redacted] 19. Dept.: Library	20. Work Phone: 503-538-8376
21. Name of physician or health-care professional: Pat Truhn	22. If medical treatment was given away from the worksite, print name and address of facility: Providence Medical Group/St 16770 SW Edy Rd Suite 10 Sherwood OR 97140
23. Were you hospitalized overnight as an inpatient? ☒ No ☐ Yes	
24. Were you treated in the emergency room? ☒ No ☐ Yes	

25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature: [redacted]	27. Completed by (please print): [redacted]	28. Date: 7/6/11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: City of Newberg Library	30: Phone: 503-538-8376	31. FEIN: 93-6002221
32. If worker leasing company, List client business name:		33. Client FEIN:
34. Address of principal place of business (not P.O. box): 414 E. First St. Newberg, OR 97132		35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 503 E. Hancock St. Newberg ZIP: 97132		37. Nature of business in which worker is/was supervised: municipal government
38. Street address, city, and State where event occurred: 503 E. Hancock St. Newberg		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No		40. NCCI code: 8810
41. Were other workers injured? ☐ Yes ☒ No	42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim: 7/1/11	45. Worker's weekly wage: $14.97/hr. 46. Date worker hired: 7/1/2008	47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☐ Regular Date: ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J. Green	51. Name, title and phone (print): REBECCA J. GREEN HR manager 503.537-1261	52. Date: 7/6/11

801

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

x801 1/05

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, middle) [redacted]			JOB TITLE: Police Officer
1. Date of injury or illness: 7 12 11	2. Date you left work: N/A	3. Shift on day of injury: 9 (from) ☒ a.m. ☐ p.m. (to) ☐ a.m. ☒ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☒ T ☒ F ☒ S ☐ S
5. Time of injury or illness: 2030 ☐ a.m. ☒ p.m.	6. Time you left work: no time lost ☒ a.m. ☐ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? ☐ Left ☒ Right (Example: sprained right foot) Cut hand			9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials) Climbing through Plank fence Searching for a fugetive got stuck w/nail			
11. Name of Witnesses: Jessica VanHorn			12. Have you previously injured or sought treatment for this body part? ☒ No ☐ Yes
13. Your legal name: [redacted]		14. Birthdate: [redacted]	15. Gender: ☒ M ☐ F
16. Mailing address, city, state and zip: [redacted]			17. Home Phone: [redacted]
18. SSN [redacted]	19. Dept.: Police		20. Work Phone: 538 8321
21. Name of physician or health-care professional: Jeremy Swindle		22. If medical treatment was given away from the worksite, print name and address of facility: PNMC - ED	
23. Were you hospitalized overnight as an inpatient? ☒ No ☐ Yes			
24. Were you treated in the emergency room? ☐ No ☒ Yes			

25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature: [redacted]	27. Completed by (please print): [redacted]	28. Date: 7 13 11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: City of Newberg P.D	30: Phone: 503-538-8321	31. FEIN: 93-6002221
32. If worker leasing company, List client business name:		33. Client FEIN:
34. Address of principal place of business (not P.O. box): 414 E. First St. Newberg OR 97132		35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 401 E Third St. Newberg ZIP: 97132		37. Nature of business in which worker is/was supervised: municipal government
38. Street address, city, and State where event occurred: 405 W. Sheridan St. Newberg OR 97132		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No		40. NCCI code: 7720
41. Were other workers injured? ☐ Yes ☒ No	42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim: 7/13/11	45. Worker's weekly wage: mon. $ 547.6	46. Date worker hired: 7/16/98
47. If fatal, date of death:		
48. Return-to-work status: ☐ Not returned ☒ Regular Date: 7/13/11 ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J Green	51. Name, title and phone (print): Rebecca J. Green, HR manager - 503 537-1361	52. Date: 7/13/11

801

x801 1/05

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, middle) [redacted]		JOB TITLE: Fleet maintenance Manager	
1. Date of injury or illness: 7-12-11	2. Date you left work: 7-12-11	3. Shift on day of injury: (from) ☑ a.m. ☑ p.m. (to) ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☑ S ☑ S
5. Time of injury or illness: 4:00 ☐ a.m. ☑ p.m.	6. Time you left work: 4:00 ☐ a.m. ☑ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? ☐ Left ☐ Right (Example: sprained right foot) Hit Head Floor		9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):	

10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials)

Walking Legs shaking and fell to the Floor, passed out / transported to hospital

11. Name of Witnesses: Craig Benedict	12. Have you previously injured or sought treatment for this body part? ☐ No ☑ Yes	
13. Your legal name: [redacted]	14. Birthdate: [redacted]	15. Gender: ☑ M ☐ F
16. Mailing address, city, state and zip: [redacted]		17. Home Phone [redacted]
18. SSN:	19. Dept.: PW Maintenance	20. Work Phone: 503. 537-1232
21. Name of physician or health-care professional: Christy Shoppe	22. If medical treatment was given away from the worksite, print name and address of facility: Newberg Hospital / Dr. Shoppe	
23. Were you hospitalized overnight as an inpatient? ☑ No ☐ Yes		
24. Were you treated in the emergency room? ☐ No ☑ Yes		

25. **By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature: [redacted]	27. Completed by (please print): [redacted]	28. Date: 07-13-11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: City of Newberg PWM	30: Phone: 503-537-1234	31. FEIN: 93-6002221
32. If worker leasing company, List client business name:		33. Client FEIN:
34. Address of principal place of business (not P.O. box): 414 E. First St. Newberg, OR 97132		35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 500 W. Third St. Newberg OR ZIP: 97132		37. Nature of business in which worker is/was supervised: municipal government
38. Street address, city, and State where event occurred: 500 W. Third St. Newberg, OR 97132		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☑ No		40. NCCI code: 8380
41. Were other workers injured? ☐ Yes ☑ No	42. Did injury occur during course and scope of job? ☐ Unknown ☑ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim: 7/12/11	45. Worker's weekly wage: monthly $ 4984.	46. Date worker hired: 9/25/89
47. If fatal, date of death:		
48. Return-to-work status: ☐ Not returned ☑ Regular Date: 7/13/11 ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J. Green	51. Name, title and phone (print): Rebecca J. Green. HR Manager, 503-537-1261	52. Date: 7/13/11

801

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

x801 1/05

Safety Committee Agenda
July 6 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of June 1, 2011

Inspections:
Second Quarter Inspections: Status ?
April 2011-June 2011

P.S. Bldg, Animal Shelter, P.W. Yard – Caleb Karen (Completed)
Wastewater Treatment and Water plants – Becky & Craig
Library and Annex – Lori & Andy (Completed)
City Hall and Archives, PSB –Jason & Melissa
Fire Dept-NFD Alex Haven (Station 20 & 21 completed)

Issues of note:
Cords across work areas / Cabinets not secured/trip hazard - Leaking Air cylinder PWM – corrected during inspection

Third Quarter Inspection assignments
July – September 2011

Animal Shelter and P.W. Yard –.Lori & Craig
Wastewater Treatment and Water plants – Karen & Andy
Library and Annex Bldg – Jason & Melissa
City Hall, Archive Bldg, PSB – Becky & Caleb
Fire Dept-NFD Alex Haven

Old Business:

Anti Slip resurfacing ADA ramp – Library – Status

Inspection Forms – Revisions due August 3rd Meeting

Risk Mngmt Grant Projects: Status

New Business:

Massage Program Status

Incident Reports:
(New) Knee Injury - Operations
(New) Leg Puncture Wound - PWM

Reports or Items from Departments:

August and September Lunch Coordinators:

Adjourn

Safety Committee Agenda
June 1 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of May 4, 2011

Inspections:
Second Quarter Inspections:
April 2011-June 2011

Animal Shelter and P.W. Yard – Karen & Caleb (completed)
Wastewater Treatment and Water plants – Becky & Craig
Library and Annex – Lori & Andy (completed)
City Hall, Archive Bldg, PSB– Jason & Melissa
Fire Dept – Alex Haven
Be sure you notify the department at least 24 hrs in advance that you will be conducting inspection.

Issues from last quarter:
Equipment and storage items blocking walking areas/exists/fire extinguishers - **library annex and Archives**
Cords across walk area/trip hazard – **IT room at PSB**
ADA Ramp surface, emergency exit 2nd floor obstructed by items – **Library**
Eyewash not flushed checked recently – **City Hall Basement floor**
Overall several inspections sited "housekeeping" issues – boxes, dried out xmas trees, storage on floors, cords etc

Old Business:

Final Invoice for Wellness Fair – Strong Hands/status

City Hall Eng Floor Allergy issues – HVAC repair status

Canopy storage at Library Annex – Response from Director
Anti Slip resurfacing ADA ramp – Library – Status
Library door lock - Status

Inspection Forms – ongoing by all members

New Business:

Review Risk Mngt Grant projects – Status

Incident Reports:
(New) NPD Tissue Strain / Motorcycle

Reports or Items from Departments:

July Lunch Coordinator: Lori

Adjourn 1:30pm

Safety Committee Agenda
May 4th 2011 12:30
Public Safety – Training Room

Call to Order
Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of April 6, 2011

Inspections:
Second Quarter Inspections:

April 2011-June 2011
Animal Shelter and P.W. Yard – Karen & Caleb
Wastewater Treatment and Water plants – Becky & Craig
Library and Annex – Lori & Andy
City Hall, Archive Bldg, PSB– Jason & Melissa
Fire Dept – Alex Haven
Be sure you notify the department at least 24 hrs in advance that you will be conducting inspection.

Issues from last quarter :
Equipment and storage items blocking walking areas/exists/fire extinguishers - **library annex and Archives**
Cords across walk area/trip hazard – **IT room at PSB**
ADA Ramp surface, emergency exit 2nd floor obstructed by items – **Library**
Eyewash not flushed checked recently – **City Hall Basement floor**
Overall several inspections sited "housekeeping" issues – boxes, dried out xmas trees, storage on floors, cords etc

Old Business:

- Wrap up any final business from Wellness Fair
  - Volunteer to send Vendors thank you letter for participating
  - Final invoices or bills

City Hall Eng Floor Allergy issues –
- Work order to Maint to speak with janitorial re: products ?
- Plan – allow HVAC work to be completed then revaluate/ if needed investigate small Air Pur. Units.

New Business:
Fair warning to workers - fumes or dust / employees need to be given advance fair warning

Volunteer for June and July lunch orders

Inspection Forms – customize to each department – set due date for revisions.

Incident Reports:
(New) Fall at Library Annex 801form
(New) Back Strain at City Hall 801form
(New) Health Exposure – NPD 801 form

Reports or Items from Departments:

djourn 1:30pm

Safety Committee Agenda
April 6, 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:

Minutes from the Safety Committee Meeting of March 2, 2011

Inspections:

First Quarter Inspections:

January 2011- March 2011

Animal Shelter, P.W. Yard – Becky & Craig
Wastewater Treatment and Water plants – Melissa & Lori (*WWT completed – WTP pending*)
Library and Annex – Caleb & Andy *(Completed)*
City Hall, Archive Bldg, PSB – Karen & Craig *(Completed)*
Fire Dept – NFD Alex Haven *(Completed)*
Be sure you notify the department at least 24 hrs in advance that you will be conducting inspection.

Issues of note:
Equipment and storage items blocking walking areas/exists/fire extinguishers - library annex and Archives
Cords across walk area/trip hazard – IT room at PSB
ADA Ramp surface, emergency exit 2nd floor obstructed by items – Library
Eyewash not flushed checked recently – City Hall Basement floor
Overall several inspections sited "housekeeping" issues – boxes, dried out xmas trees, storage on floors, cords etc –
Reps please remind depts about "Housekeeping" requirement from OSHA

Second Quarter Inspections:

April 2011-June 2011

Animal Shelter and P.W. Yard – Karen & Caleb
Wastewater Treatment and Water plants – Becky & Craig
Library and Annex – Lori & Andy
City Hall, Archive Bldg, PSB– Jason & Melissa
Fire Dept – Alex Haven

Old Business:

- Wellness Fair – Set up at 10am April 14th PSB
  - Vendors – Andy
  - Food /Drinks – Melissa
  - Flyers & Emails – Karen (completed)
  - Give away items – Caleb (completed)
  - Set up – cords, tables etc Lori & Craig (Craig to Coordinate with Clinton)
  - Any other issues to discuss?

New Business:

Jason W - City Hall Basement area concerns with Allergens in Air system or carpeting.

Incident Reports:

(New) Fall at Library Annex 801form
(New) Back Strain at City Hall 801form

eports or Items from Departments:

Next Meeting Lunch Orders arranged by Caleb

Adjourn 1:30pm

Safety Committee Agenda
March 2, 2011 12:30
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:

Minutes from the Safety Committee Meeting of February 2, 2011

Inspections:

First Quarter Inspections:

January 2011- March 2011

Animal Shelter, P.W. Yard – Becky & Wayne
Wastewater Treatment and Water plants – Melissa & Lori
Library and Annex – Caleb & Andy
City Hall, Archive Bldg, PSB – Karen & Craig *(Archive & PSB completed)*

Fire Dept – NFD Alex Haven *(Station 21 completed)*

Be sure you notify the department at least 24 hrs in advance that you will be conducting inspection.

Old Business:

- Update: City Hall Hatch – completed
- Update: Wayne – Status wellness fair – assignment of duties for fair
- Update: Karen – Vent Cover at Achieve Bldg- pending

New Business:

City Hall AED: Training Dates – March 16th

Class 1: 8:30am to 9:15 Class 2: 9:15am to 10am Class 3: 10am to 10:45am Class 4: 10:45am to 11:30am

March 15 1-3pm

Free Course recommended for any staff that supervise/train employees or any personnel that are responsible for the OSHA required record keeping regarding PPE Training. It is 2 hrs in length.
Register at http://www.cisoregon.org/MS/training.aspx?id=741

Wellness Magazines – continue or create in house ? Subscription renews end of March 2011.

Incident Reports:

Reports from Departments:

Adjourn 1:30pm

Safety Committee Agenda
February 2 2011 Noon
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of January 5th, 2011

Inspections:
First Quarter Inspections:

January 2011- March 2011
Animal Shelter, P.W. Yard – Becky & Wayne
Wastewater Treatment and Water plants – Melissa & Lori
Library and Annex – Caleb & Andy
City Hall, Archive Bldg, PSB – Karen & Craig

Fire Dept – NFD Alex Haven
Be sure you notify the department at least 24 hrs in advance that you will be conducting inspection.

Old Business:

- Update: Andy/Becky – Risk Management Grant application status
- Update: Craig - City Hall Hatch – has it been repaired or fixed since last injury.
- Update: Becky -Ergonomic Chair for IT employee
- Update: Wayne – Status wellness fair
- Update: Karen – Vent Cover at Achieve Bldg
- Update: Karen – Revised Injury Form
- Update: Karen – Safety Vests

New Business:
Massage program – change in schedule to July – budget ?

Incident Reports:
Form 801 NPD – Auto Accident
Form 801 PWM – RM/Ergonomics injury

Reports from Departments:

Guest: Adrian Albrich CIS – Topic Inspections

Adjourn 1:30pm

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, middle) [redacted]			JOB TITLE: Fleet maintance Manager
1. Date of injury or illness: on going	2. Date you left work: still working	3. Shift on 8:00 (from) ☑ a.m. ☐ p.m. day of injury: 4:30 (to) ☐ a.m. ☒ p.m.	4. Regularly scheduled days off: ☐ ☐ ☐ ☐ ☐ ☑ ☑ M T W T F S S
5. Time of injury or illness: 1/29/11 ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? ☑ Left ☐ Right (Example: sprained right foot) hands go numb		9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):	
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials) The use of hand tools do to repitive use is causing numbness need test to find problem.			
11. Name of Witnesses:		12. Have you previously injured or sought treatment for this body part? ☑ No ☐ Yes	
13. Your legal name: [redacted]		14. Birthdate: [redacted]	15. Gender: ☑ M ☐ F
16. Mailing address, city, state and zip: [redacted] Newberg OR 97132			17. Home Phone [redacted]
18. SSN: [redacted]		19. Dept.: Public Works maintence	20. Work Phone: 503-537-1232
21. Name of physician or health-care professional: Dr Shoppe		22. If medical treatment was given away from the worksite, print name and address of facility: ville medical clinic 503-538-0411	
23. Were you hospitalized overnight as an inpatient? ☑ No ☐ Yes			
24. Were you treated in the emergency room? ☑ No ☐ Yes			

25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature: [redacted]	27. Completed by (please print): [redacted]	28. Date: 01-31-11

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: City of Newberg	30: Phone: 503-537-1234	31. FEIN: 93-6002221
32. If worker leasing company, List client business name:		33. Client FEIN:
34. Address of principal place of business (not P.O. box): 500 W. Third St. / 414 E First St		35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 500 W Third St. Newberg ZIP: 97132		37. Nature of business in which worker is/was supervised: municipal government
38. Street address, city, and State where event occurred: 500 W. Third St. Newberg OR 97132		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No		40. NCCI code: 8380
41. Were other workers injured? ☐ Yes ☒ No	42. Did injury occur during course and scope of job? ☐ Unknown ☑ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim: 1/31/11	45. Worker's weekly wage: $ 4984 (wa)	46. Date worker hired: 9/25/89
47. If fatal, date of death:		
48. Return-to-work status: ☐ Not returned ☒ Regular Date: ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Rebecca J Green	51. Name, title and phone (print): REBECCA J. Green, HR manager. 503-537-1261	52. Date: 1/31/11

801

x801 1/05

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

CIS Workers Compensation Group
c/o City County Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Workers' compensation claim

Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

NAME: (Last, first, middle) [redacted]		JOB TITLE: Police Officer	
1. Date of injury or illness: 01/04/2011	2. Date you left work: 01/4/2011	3. Shift on day of injury: 4:00 (from) ☐ a.m. ☒ p.m. 2:00 (to) ☒ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☒ F ☒ S ☒ S
5. Time of injury or illness: 6:17 ☐ a.m. ☒ p.m.	6. Time you left work: 6:45 ☐ a.m. ☒ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? ☐ Left ☐ Right (Example: sprained right foot) Vehicle accident		9. Workers' language preference other than English: ☐ Spanish ☐ Other (please specify):	

10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carry a 40 lb. box of roofing materials)

I was driving a patrol car and was hit as I made a u-turn.

11. Name of Witnesses: [redacted]	12. Have you previously injured or sought treatment for this body part? ☒ No ☐ Yes	
13. Your legal name: [redacted]	14. Birthdat[redacted]	15. Gender: ☒ M ☐ F
16. Mailing address, city, state and zip: [redacted]		17. Home Phone [redacted]
18. SSN: [redacted]	19. Dept.: NDPD - Newberg - Dundee	20. Work Phone: 503-538-8321
21. Name of physician or health-care professional: Dr. Haddelund	22. If medical treatment was given away from the worksite, print name and address of facility: N/A	
23. Were you hospitalized overnight as an inpatient? ☒ No ☐ Yes		
24. Were you treated in the emergency room? ☐ No ☒ Yes		

25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

26. Worker Signature: [redacted]	27. Completed by (please print): [redacted]	28. Date: 1/6/2011

Employer

Complete the rest of this form and give a copy of the form to the worker and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. Employer legal Business name: City of Newberg PD	30: Phone: 503-538-8321	31. FEIN: 93-6002221
32. If worker leasing company, List client business name:		33. Client FEIN:
34. Address of principal place of business (not P.O. box): 401 E. Third St. Newberg OR 97132		35. Insurance policy no.:
36. Street address from which Worker is/was supervised: 401 E. Third St. Newberg OR ZIP: 97132		37. Nature of business in which worker is/was supervised: Municipal Government
38. Street address, city, and State where event occurred: Hwy 219 & Sitka, Newberg OR		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☒ No		40. NCCI code: 7720
41. Were other workers injured? ☐ Yes ☒ No	42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim: 1/4/11	45. Worker's weekly wage: [redacted] mon.	46. Date worker hired: 1/4/10
47. If fatal, date of death:		
48. Return-to-work status: ☐ Not returned ☒ Regular Date: 1/6/11 ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
Employer signature: Rebecca J. Green	51. Name, title and phone (print): REBECCA J. GREEN, HR Manager 503-537-1261	52. Date: 1/6/11

801

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 452-0311, on nights and weekends.

801

x801 1/05

City Attorney
503) 537-1206

City Manager
503) 538-9421

City of Newberg

115 South Howard Street
PO Box 970
Newberg, Oregon 97132

INCIDENT REPORT

(TO BE COMPLETED BY CITY STAFF)

DATE OF INCIDENT: 1-4-11

NAME OF PERSON REPORTING INCIDENT: [redacted]
CITY DEPARTMENT: Police TELEPHONE NO: [redacted]

NAME OF INJURED PARTY OR OWNER OF DAMAGED PROPERTY: [redacted]

ADDRESS: [redacted]
TELEPHONE NO. [redacted]

EXACT LOCATION OF INCIDENT (BE SPECIFIC): Hwy 219 / Sitka Ave

BRIEFLY DESCRIBE *EXACTLY* WHAT HAPPENED: Officer [redacted] was driving his police car and attempted a U turn to catch a violator. He activated his overhead lights and turned. He was struck by a car which had been following behind him.

TO WHOM WAS INCIDENT REPORTED: Cooke DATE REPORTED: 1-4-11
POLICE CALLED? Yes FIRE DEPT. CALLED? Yes.

NAME OF WITNESS(ES):

Name	*Telephone No.*	*Address*
[redacted]		

● CITY ATTORNEY'S OFFICE: e-mail: nlegal@ci.newberg.or.us *Fax:* 537-1277 ●
Building: 537-1240 ● Community Development: 537-1210 ● Finance: 537-1201 ● Fire: 537-1230
Library: 538-7323 ● Municipal Court: 537-1203 ● Police: 538-8321 ● Public Works: 537-1214 ● Utilities: 537-1205
Municipal Court *Fax*: 537-1277 ● Community Development *Fax*: 537-1272 ● Library *Fax*: 538-9720

Safety Equipment/ Personal Protective Equipment In Use At Time of Accident/Incident:

Safety belt

Describe what happened (include sequence of events; equipment, materials, and substances being used; and environment – PLEASE BE SPECIFIC): Officer [redacted] was driving his police car and attempted a U turn to catch a violator. He activated his overhead lights and turned. He was struck by a car which had been behind him.

How long have you been doing this particular job?: One year.

Have you had any similar incidents in the past? Yes _____ (No) _____ (If yes, please describe by including date, type of incident, and if any action was taken): _____

Have you injured this part(s) of your body previously or is there any pre-existing condition that could affect the injury? Yes _____ (No) _____ (if yes, please explain): _____

What do you think can be done to prevent this incident from reoccurring? _____

To Be Completed By Employee's Supervisor:

Why did the accident/incident happen or the condition exist? Inattention.

What could have been done, or should be done, to prevent this accident/incident?: More attention.

Have there been accidents or incidents in this same activity? Was action taken? No.

****Please Provide Witness Information On A Separate Piece of Paper****

Employee's Signature: [redacted] Date: 01/05/2011

Supervisor's Signature: Mark Isom Date: 1-4-11

Risk Manager's Signature: _____ Date: _____

SAFETY COMMITTEE EVALUATION OF ACCIDENT/INCIDENT

Corrective Action Needed: _____

Corrective Action Assigned To (if applicable): _____

Date Corrective Action Completed: _____

Committee Recommendations: _____

Safety Committee Meeting Minutes
January 5, 2011 1 p.m.
Public Safety Building

Present:
Chair Karen Tarmichael (WWTP), Lori Biever-Launder (Library), Wayne Ginter (Planning/Building), Craig Brault (PW Maintenance), Becky Green (Administration), Karan Frketich (NPD on behalf of Melissa Cleveland), Andy Willette (NFD).

Review and Approval of Minutes:

MOTION#1: Willette/Green motioned and seconded to approve the minutes from the Newberg Safety Committee of December 1, 2010. (7 Yes).

OLD BUSINESS

- **First Quarter Inspection assignments** – *remember to provide 24+ hours notice prior to conducting inspections; to be completed by the end of September.*
  P.S. Bldg, Animal Shelter, P.W. Yard – Becky and Wayne
  Wastewater Treatment and Water plants – Melissa and Lori
  Library and Annex – Caleb and Andy
  City Hall and Archives –Karen and Craig

  Fire Dept-NFD Alex Haven

- Fourth quarter inspections are completed
- Risk Management grant application is ready to be submitted
- The new handrail at the library has been installed

NEW BUSINESS

- The Wellness Fair will be set for April 14th in the PSB room.
- The new schedule for inspections is available.
- Suggestion to provide safety vests: PW has used safety vests to donate to city hall. The library will check to see if the department will use them.
- Use analysis before incident report 801, changing the verbiage on the blue sheet from accident/incident to injury/exposure
- Incident reports were discussed

Meeting adjourned at 1:52 p.m.

Safety Committee Agenda
January 5, 2011 1 p.m.
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of December 1st, 2010

Inspections:
Fourth Quarter Inspections: Complete – comments issues questions

First Quarter Inspections:

January 2011- March 2011
Animal Shelter, P.W. Yard – Becky & Wayne
Wastewater Treatment and Water plants – Melissa & Lori
Library and Annex – Caleb & Andy
City Hall, Archive Bldg, PSB – Karen & Craig

Fire Dept – NFD Alex Haven
Be sure you notify the department at least 24 hrs in advance that you will be conducting inspection.

Old Business:

- **Update:** Andy/Becky – Risk Management Grant application status
- New safety railing at Library has been installed.

New Business:

- Set Date for Wellness Fair – Current dates PSB Room avail in April are 7th, 13th, 14th, 20th, 21st, 27th

- Suggestion– Provide safety vests for City Hall and Library locations, for use by staff for outside activities. concern over pedestrian injuries and accidents including a recent death. Many city staff wear Navy or dark clothing/coats.

  Vests are already available at PWM and Operations, NFD and NPD have reflective clothing. Purchase, if approved, would be for @ 10 vests – 5 for Library and 5 for City Hall. Best price located Grainger at $9.91 each.

Incident Reports:
Form 801 NPD – Keyboard

Ergonomic station review / Chair – IT Dept

Reports from Departments:

Adjourn 2:00pm

Safety Committee Agenda
January 5, 2011 1 p.m.
Public Safety – Training Room

Call to Order

Review and Approval of Minutes:
Minutes from the Safety Committee Meeting of December 1st, 2010

Inspections:
Fourth Quarter Inspections: Complete – comments issues questions

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Animal Shelter, P.W. Yard – Becky & Wayne
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Library and Annex – Caleb & Andy
City Hall, Archive Bldg, PSB – Karen & Craig

Fire Dept – NFD Alex Haven
Be sure you notify the department at least 24 hrs in advance that you will be conducting inspection.

Old Business:

- **Update:** Andy/Becky – Risk Management Grant application status
- New safety railing at Library has been installed.

forward form to Karen – Injury/Exposure - Thursday

New Business:

- Set Date for Wellness Fair – Current dates PSB Room avail in April are 7th, 13th, (14th) thurs. 20th, 21st, 27th

- Suggestion– Provide safety vests for City Hall and Library locations, for use by staff for outside activities. concern over pedestrian injuries and accidents including a recent death. Many city staff wear Navy or dark clothing/coats. Karen contact Russ - for some used ones –

  Vests are already available at PWM and Operations, NFD and NPD have reflective clothing. Purchase, if approved, would be for @ 10 vests – 5 for Library and 5 for City Hall. Best price located Grainger at $9.91 each.

Incident Reports:
Form 801 NPD – Keyboard
– Clinton / Dawn Karen
Ergonomic station review / Chair – IT Dept

Reports from Departments:

Adjourn 2:00pm

166-200-0140
Risk Management Records

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(12) **Safety Program Records** Records document the city's program to promote a safe work environment for its employees. Records may include safety policies, plans and procedures, workplace safety committee records, reports on inspections conducted by the safety officer, evacuation rosters and reports, and related documentation and correspondence. (Minimum retention: (a) Safety policies, plans and procedures, retain 5 years after superseded; (b) Inspection reports, reports, evaluations and recommendations, retain 10 years; (c) Committee minutes, exhibits and agendas, retain 3 years; (d) All other records, retain 5 years).

(13) **Workers' Compensation Claim Records** Records document the processing of individual employee claims of job related injuries or illnesses, but not those describing actual medical conditions. Includes records satisfying the procedural requirements of the State Workers' Compensation Division and the State Workers' Compensation Board, as well as those of (depending on city arrangements) the State Accident Insurance Fund (SAIF), private insurance providers, or self insurance. Records may include claim disposition notices, claim reporting and status forms; injury reports; determination orders; insurance premium data; hearing requests; safety citations; inspection reports; medical status updates and reports; investigation reports; reimbursement and payment records; and related correspondence and documentation. SEE ALSO Employee Medical Records in the Personnel section for records describing the job related injury or illness and the related subsequent medical condition of the employee. These often include workers' compensation accident reports, medical reports, vocational rehabilitation evaluations, disability determinations and related records. (Minimum retention: (a) For retention of records describing injuries and illnesses, see Employee Medical Records in the Personnel section; (b) All other records, retain 6 years after claim closed or final action).

Stat. Auth.: ORS 192 & ORS 357
Stats. Implemented: ORS 192.005 - ORS 192.170 & ORS 357.805 - ORS 357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02

SAFETY COMMITTEE MEMBERS
2011

Karen Tarmichael – PW Operations – Chair
Andy Willette – Fire Dept.
Wayne Ginter – Building/City Hall
Melissa Cleveland – Police Dept.
Lori Biever-Launder – Library
Craig Brault – Public Works Maintenance
Caleb Lippard – Finance
Becky Green – HR/Administration