STANDARD PROCEDURE

CITY OF WILSON				PERSONNEL MANUAL
SUBJECT	**NUMBER**	**EFFECTIVE DATE**	**SUPERSEDES**	
Accident/Incident Reporting	F-2	April 2018	Safety Manual Policy	Page **1** of **4**
Prepared By: Human Resources			Approved By: Harry Tyson, Deputy City Manager	

1.0 Purpose

To provide policy and procedures to be followed in the event a City of Wilson (City) employee is involved in an accident or incident that arose out of and in the course of employment.

2.0 Scope

All employees are covered under this policy.

3.0 Definitions

3.1 **Approved Physicians/Facilities:** The physician(s)/facilities approved by the City of Wilson Human Resources department to provide medical care for City employees. At the time of this policy revision, Wilson Immediate Care, Wilson Medical Center Emergency Room, Wilson Eye Associates and the Employee Health and Wellness Facility (EHWC) are the designated medical facilities approved to provide initial care and treatment of City employees.

4.0 Forms

4.1 For a summary of required forms and when each is needed, see Appendix A attached.

5.0 Procedures

5.1 Reporting During Regular EHWC Hours (Monday – Friday, 7 a.m. – 4 p.m.)

5.1.1 *Employees shall report all injuries, no matter how small or insignificant, to their supervisor immediately.*

5.1.2 The immediate supervisor shall be responsible for getting the injured employee medical attention in collaboration with Human Resources personnel.

5.1.2.1 The *Medical Services Pass* authorizing medical treatment shall be obtained from Human Resources and taken by the employee to the approved medical facility. (See Appendix B attached).

5.1.2.2 All ongoing/follow-up treatment and authorization for prescriptions will be coordinated through Human Resources.

5.1.3 All injuries requiring medical treatment must be authorized by Human Resources and except for severe emergencies, will be treated at the EHWC and/or Wilson Immediate Care.

5.2 After Hours Reporting

5.2.1 The employee shall notify his/her supervisor before seeking treatment after hours, as feasible.

5.2.2 Supervisors shall contact the after-hours Human Resources designee immediately after receiving notification of an employee injury.

5.2.3 As applicable, the supervisor shall complete a Medical Services Pass and state that the employee visited the hospital emergency room after hours.

5.3 Medical Care Requirements

5.3.1 All injuries that are deemed work-related and potentially covered by Workers' Compensation laws will be seen by a City approved physician. Injured employees must continue to be seen by the designated physician unless they are referred out to a specialist. If an employee desires a second opinion on

his/her care or treatment plan, prior permission must be obtained from the Workers' Compensation Coordinator.

Note: Failure to adhere to section 5.3.1 requirements may result in denial and/or discontinuance of Workers' Compensation benefits and employee being required to pay all medical treatment costs out-of-pocket. Payment of personal physician services for a Workers' Compensation injury will be denied.

5.4 **Use of Emergency Room**

5.4.1 An employee may utilize the hospital emergency room for injuries only for the following:

5.4.1.1 After work hours when Human Resources offices are closed, **and**

5.4.1.2 Wilson Immediate Care is closed, **and**

5.4.1.3 Injuries obviously require hospital admittance, **or**

5.4.1.4 In life-threatening emergencies.

5.5 **Use of EMS/Rescue Squad**

5.5.1 In the event of a life-threatening situation, or one which will obviously require hospital admittance, EMS/Rescue Squad services will be dispatched to transport the employee to the emergency room.

5.6 **Injury Investigation**

5.6.1 The supervisor will investigate the accident and complete the *City of Wilson Supervisor Accident/Injury Investigation Report*. (See Appendix C attached).

5.6.2 The supervisor will be responsible for ensuring the following are completed:

5.6.2.1 The employee involved in the accident/injury will complete the *City of Wilson Employee Accident Report*. (See Appendix C attached).

5.6.2.2 Witnesses to the accident will complete the *City of Wilson Employee Witness Statement Form*. (See Appendix D attached).

5.6.2.3 All forms are completed and forwarded to the Human Resources office to the attention of the Workers' Compensation Coordinator.

6.0 Procedures Involving Vehicles/Equipment

6.1 The following procedures are to be followed immediately after a vehicle accident:

6.1.1 If there are injuries or other emergency conditions (i.e., fuel leak, chemical spill), notify Wilson Emergency Communications Center (911). Be prepared to give such details as:

6.1.1.1 Who is injured;

6.1.1.2 How they were injured;

6.1.1.3 Description of injuries;

6.1.1.4 Vehicles involved.

Note: All accidents involving City vehicles will be investigated by City Police or State Highway Patrol.

6.1.2 Employees must notify their supervisor of the accident as soon as possible.

6.1.3 The employee and/or supervisor must immediately notify the Human Resources Safety & Risk Coordinator (or his/her designee) of the accident.

6.1.3.1 The *City of Wilson Vehicle/Equipment Accident Report* and the *City of Wilson Supervisor Vehicle Accident Investigation Report* will be

completed and forwarded to the Human Resources office as soon as possible. (See Appendixes F and G attached)

6.1.4 Employees will check on any victims and assist with ensuring safety at the scene, as feasible.

6.1.5 Employees will refrain from making any statement to any person or representative other than City management or the investigation police officer, including but not limited to, admitting guilt or fault relating to actions by themselves or any other person that may or may not have contributed to the accident.

6.2 For accidents/incidents involving citizens, the same procedures apply as listed in 6.1.1 and 6.1.2. In addition:

6.2.1.1 If damage occurs to a citizen's property (e.g., sewer back-up, gas meter issue, cut utility line), a *General Liability Incident Report* must be completed by the employee involved, signed by the supervisor and submitted to Human Resources. (See Appendix H attached).

6.2.1.2 If the incident involved involves a street cut, a *Street Cut Claim* form must be completed by the supervisor and submitted to Human Resources. (See Appendix I attached).

7.0 Disciplinary Actions

7.1 As prompt action is critical to properly investigate an injury and/or vehicle accident, find the cause and develop corrective actions to prevent future accidents, and reduce the potential liability for the City, especially if there are federal and state regulations to be complied with, infractions of this policy may result in disciplinary action up to and including termination, including but not limited to:

7.1.1 Failure of the employee to immediately report a vehicle accident to their supervisor.

7.1.2 Failure to notify the Safety & Risk Coordinator or his/her designee immediately following a vehicle accident, which could prevent or prolong the time between the accident and post-accident drug & alcohol testing, as required.

7.1.3 Operating a City vehicle post-accident when the employee is required to perform a post-accident drug/alcohol test.

7.1.4 Operating a City vehicle post-accident before Human Resources has given approval for driving privileges to resume.

7.1.5 Making any statement regarding guilt or fault to anyone other than the investigating officer and/or Human Resources.

7.1.6 Falsifying any documentation

7.1.7 Directing a City employee to violate any rule within this policy.

I acknowledge receipt of the Accident/Incident Reporting policy. I have read and understand the information outlined, have had the opportunity to ask questions for clarification, and agree to abide by the policy.

Print Name: ____

Employee Signature: ____

Department: _____________________ Date: ___________________

Policy F-2: Accident/Incident Reporting

Appendix A
Summary of Required Forms

Accident/Incident Type	Appendix	Required Form(s)	Who is responsible for completing form
Employee Injury	B	*Medical Services Pass*	HR initiates/authorizes; employee provides to approved provider
	C	*City of Wilson Employee Accident/Incident Report*	Employee
	D	*City of Wilson Supervisor Accident/Incident Investigation Report*	Supervisor
	E	*City of Wilson Witness Statement Form*	Witness (separate form for each witness, as applicable)
Vehicle/Equipment Accident (including vehicle/equipment involved in employee injury)	F	*City of Wilson Vehicle/Equipment Accident Report*	Employee driver
	G	*City of Wilson Supervisor Vehicle Accident Investigation Report*	Supervisor
Incident involving citizen's or City of Wilson property (not including motor vehicles)	H	*General Liability Incident Report*	Employee/Supervisor
Street cut related incident involving a citizen	I	*Street Cut Claim*	Initiated by HR as needed

City of Wilson
P.O. Box 10
Wilson, NC 27894-0010

Appendix B

Medical Services Pass

☐ EHWC ☐ Wilson Immediate Care ☐ Other (specify) _______________

Part 1	**Supervisor's Immediate Report of Injury**	
Employee's Name	Date	Department

Worker's Comp. ☐ Yes ☐ No ☐ Modified Light Duty Evaluation

Date of Occurrence _______________ Time ________ A.M. _________ P.M. Location___________________

Description of Accident:

____

____

Referred to Medical Care: ☐ Yes
☐ No Time left job site for clinic ________ A.M. ___________P.M.

Supervisor Name (Print): ______________________________________

Supervisor Signature: ____

Telephone:
____

Part 2	**Medical Disposition**

☐ Medically acceptable for work
☐ Medically acceptable for work with restrictions
☐ Medically not acceptable for work until _____________
☐ To see other doctor
☐ No further treatment

TIME
In: ___________ A.M. ______________P.M.
Out: __________ A.M. ______________ P.M.

Follow-up Date: _____________ Time: _________ A.M. _________ P.M.

Signature: ____R.N./M.D.

Note: The City of Wilson has established a Light Duty Policy which encourages expedient return to work by offering light duty assignments, as available, for employees requiring specific job restrictions as a result of an injury or medical condition. Please indicate specific restrictions and/or modifications required for this employee.

Supplemental Medical Comments
Diagnoses/Treatment/Medications/Restrictions
Date ____________________ Signature ____ R.N./M.D.

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Appendix C

CITY OF WILSON EMPLOYEE ACCIDENT/INCIDENT REPORT

Instructions: Employee must complete report. If more room is needed, you may continue on the back of this form and/or attach additional pages if necessary.

Employees are required to complete this form for all incidents and near misses. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

Supervisor Review: If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report on the employee's behalf. My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Sign below only if you assisted with the completion of this form.

Supervisor Name:____________________________Signature:______________________________Date__________

Employee Information			Date/Location Information	
Name (Full):			Date of Incident:	Time of Day:
Home Address:			Date Reported to Supervisor:	Time of Day:
City: Zip:		☐ Male ☐ Female	Work Address:	
Telephone #:				
Job Title:			Incident Location (address, building name, office, cross streets, fire name, woods, facility, room #, etc.):	
Department:				
Supervisor:	Phone #:			
Time report to work:	Medical Treatment _Yes _ No			

If yes, where: ☐ City Nurse ☐ Wilson Immediate Care ☐ Wilson ER ☐ Other

Were there any witnesses to the incident? _ Yes _ No Number of Witnesses (if applicable):
If yes, list all known witnesses/phone #'s below, please include additional names on attachment if needed.

Name:	Phone #:
Name:	Phone #:

Medical Information

Part(s) of the body injured:

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? _ Yes _ No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

Description of Accident/Incident

What was the root cause of the incident? Ask why, and then ask why again. What was the immediate cause to this accident and did any objects and/or co-workers contribute to the accident?

Suggested Corrective Actions

I hereby certify that the information I have provided is true and accurate. And that any inaccurate or false statements may result in a delay in the processing of this claim.

Employee Name Signature Date

Appendix D

CITY OF WILSON SUPERVISOR ACCIDENT/INCIDENT INVESTIGATION REPORT

Instructions: Begin investigation within 24 hours and attach the Employee Incident Report and Witness Reports to this report. Forward all reports within 72 hours to the HR Administrator. If more room is needed, you may continue on the back of this form and/or attach additional pages if necessary.	
Division/Department:	Date of Incident:
Employee Name:	Employee Phone #:
Incident Supervisor:	Supervisor Phone #:

Incident Classification (check all that apply)
☐ Near Miss ☐ Injury ☐ Fatality ☐ Property Damage ☐ Spill ☐ Possible Blood Borne Pathogen exposure

Employee required:
☐ First-Aid Only ☐ Medical treatment and released ☐Hospitalized ☐ Other:

Employee:
☐ Returned to work no restrictions ☐ Returned to work with restrictions ☐ Did not return to work (Lost Days)

Names of Witnesses Interviewed:

Incident Information

Describe the specific activity the employee was engaged in and the sequence of events leading up to the injury or accident. Include objects or substances that directly injured or made the employee ill. Describe tools, equipment, and PPE in use. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)

Prior to beginning activity, did the employee review potential hazards/dangers?	☐ Yes ☐ No	Date employee last received training for their job responsibilities. .	/ /

What was the root cause of the incident? Ask why then ask why again. What was the immediate cause to this accident and did any objects and/or co-workers contribute to the accident?

Action taken or to be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in the processing of this claim. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.

(Please Print) Supervisor's Name:	Signature	Date of Report: / /
(Please Print) Manager's Name:	Signature	Date Reviewed / /

The Supervisor will obtain the Managers' signature and forward signed copies of the Employee Report, Witness Statements, and the Supervisor's report to the HR Administrator. The HR Administrator will send the Employee's and Supervisor's reports and all supporting documentation to the appropriate personnel.

Workers Compensation Coordinator Name:	Signature	Date / /

Date Corrective Actions Completed:

Appendix D

CITY OF WILSON SUPERVISOR ACCIDENT/INCIDENT INVESTIGATION REPORT

ACCIDENT BREAKDOWN BY CHARACTERISTIC
(check all that apply)

Nature of Injury	Part of Body Affected
☐ Amputation or Enucleation	☐ No Physical Injury
☐ Assault	☐ Head
☐ Burn or Scald	☐ Neck
☐ Contusion, Bruise	☐ Eyes (Including Vision)
☐ Electric Shock	☐ Arm(s) (Above Wrist)
☐ Eye, Foreign body in	☐ Hand(s) (Including Wrist)
☐ Fracture, Broken Bone	☐ Finger(s) and Thumb(s)
☐ Freezing, Frostbite	☐ Upper Extremity, Multiple Parts (shoulder, arm, forearm, wrist, or hand)
☐ Hearing Loss or Impairment	☐ Abdomen (Including Internal Organs)
☐ Heat Exhaustion, Sunstroke	☐ Back (Including Muscles, Spine)
☐ Hernia or Rupture	☐ Chest (Including Internal Organs)
☐ Infection	☐ Hips (Including Pelvic Organs)
☐ Inhalation Injury-Toxic Substance	☐ Shoulder(s)
☐ Insect Bites	☐ Trunk, Multiple Parts
☐ Laceration (Cut)	☐ Leg(s) (Above Ankle)
☐ Multiple Injuries	☐ Foot (Including Ankle)
☐ Needle Puncture	☐ Toes
☐ Rash, From Plants	☐ Lower Extremity, Multiple Parts (from the hip to the toes)
☐ Rash, Not From Plants	☐ Multiple Parts of Body
☐ Scratches, Abrasions	☐ Digestive System
☐ Sprain, Strains	☐ Respiratory System
☐ Other: (please explain)________________________________	☐ Circulatory System
	☐ Skin
	☐ Other: (please describe)_______________________________

Type of Accidents	Safety Equipment in Use
☐ Bodily Reactions (Sprains, Strains, Rupture, Etc.)	☐ Hard Hat
☐ Caught In, Under, Or Between	☐ Safety Glasses
☐ Contact with Temperature Extremes (Fire, Cold)	☐ Goggles
☐ Disease Exposure	☐ Face shield or welder helmet
☐ Electrical Shock	☐ Gloves
☐ Falls (All Types)	☐ Fire Shirt
☐ Noise Exposure	☐ Fire Pants
☐ Repetitive Motion	☐ Safety Shoes
☐ Rubbed or Abraded by Object	☐ Fire line Boots
☐ Struck Against Object	☐ Ear Protection
☐ Struck by Flying Object	☐ Respirator
☐ Struck by Other Object/Person	☐ Lanyards & Lifelines
☐ Toxic Materials Exposure	☐ Fluorescent Vests
☐ Vehicle or Equipment Accident	☐ Buoyant Work Vest
☐ Other: (please explain)________________________________	☐ Warning & Control
	☐ Seat Belts
	☐ Shoulder Harness
	☐ Safety Equipment, National Electrical Code (NEC)
	☐ Lab Coat
	☐ Other: (please describe)_______________________________

When submitting this report, include pictures of incident location, equipment in use, the vehicle used (if applicable), and any third party reports (i.e. Police Report, OSHA Report, etc.).

Appendix E

CITY OF WILSON EMPLOYEE WITNESS STATEMENT FORM

<table>
<tr><td colspan="2">Instructions: Before providing the required information below, please note that you will have to certify the truthfulness of this information. You will also be required to acknowledge that you understand that in addition to being disciplined for providing false and/or misleading information, up to and including dismissal, you may also be subjected to additional criminal and/or civil liability. To help you write this statement, please include, if possible, the following information:</td></tr>
<tr><td colspan="2">Type of Investigation:
☐ Incident/Accident ☐ Property Damage ☐ Near Miss ☐ Other ____________________</td></tr>
<tr><td colspan="2">Witness Information</td></tr>
<tr><td>Name:</td><td>Title:</td></tr>
<tr><td>Work Address:</td><td>Work Phone #:</td></tr>
<tr><td colspan="2">Incident Information</td></tr>
<tr><td>Date of Incident:</td><td>Time of Incident:</td></tr>
<tr><td colspan="2">Location of Incident:</td></tr>
<tr><td colspan="2">Do you have any pictures of the incident?
If yes, please attach them this submission. ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">List the names of anyone present who observed or may have knowledge of the incident.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">State what you know about the incident. Please indicate who, what, where, and when the accident occurred, being as detailed as possible. If you need more space than what is provided here, you may continue on the back of this form and/or attach additional pages if necessary.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">I hereby certify that the information I have provided is true and accurate. I acknowledge that any inaccurate or false statements may result in a delay in the processing of this claim.</td></tr>
<tr><td>Witness Name:</td><td>Witness Title:</td></tr>
<tr><td>Signature:</td><td>Date of Statement:</td></tr>
</table>

Appendix F

CITY OF WILSON VEHICLE/EQUIPMENT ACCIDENT REPORT Vehicle Accident Claim #: _________

ACCIDENT

Location: (Street(s), City		
Date:	Time:	Investigating Officer:
Describe accident in detail (use back of form to continue/diagram accident):		

DRIVER & CITY OF WILSON OWNED VEHICLE

Name			Department	Vehicle No:
Year:	Make:	Serial No:	License Plate No:	
Describe damages to the City of Wilson's vehicle:				

SECOND PARTY & NON-CITY OF WILSON VEHICLE/PROPERTY DAMAGES *Attach additional sheets with information for additional damages if necessary.

Driver:		Contact #:	
Vehicle Color:	Year:	Make and Model:	Insurance Co:
Describe damage to non-City of Wilson vehicle:			

INJURIES: *Attach additional sheets with information from injured parties if necessary.

***If Injuries are for a City of Wilson employee, complete the appropriate Employee Accident/incident report as well**

Name:	Name:
Address:	Address:
Home Phone:	Home Phone:
Describe Injuries:	Describe Injuries:

WITNESSES

Name:	Date:	Name:	Date:
Address:		Address:	

Signature, City of Wilson vehicle driver: ____Date:_______________

Appendix G

CITY OF WILSON SUPERVISOR VEHICLE ACCIDENT INVESTIGATION REPORT Vehicle Accident Claim #: _______

Instructions: Begin investigation within 24 hours and attach the Employee Reports and Witness Reports to this report. Forward all reports within 72 hours to HR. If more room is needed, you may continue on the back of this form and/or attach additional pages if necessary.

Division/Department:	Date of Accident:
Employee Name:	Employee Phone #:
Supervisor:	Supervisor Phone #:

Accident Caused by:
☐ Backing ☐ Forward Motion ☐ Turning ☐ Other (animal, object in road, etc):

If the accident involved backing, was a spotter used
☐ No Why was a spotter not used:
☐ Yes Who was the spotter:

Could the employee have avoided the accident
☐ Yes How:
☐ No Why:

Names of Witnesses Interviewed:

Incident Information

Describe the specific activity the employee was engaged in and the sequence of events leading up to the accident. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)

Were there any injuries to employees	☐ Yes ☐ No	**If Yes, Please complete the incident/accident injury forms as well**

What was the root cause of the accident? Ask why then ask why again. What was the immediate cause to this accident and did any objects and/or co-workers contribute to the accident?

Action taken or to be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in the processing of this claim. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.

(Please Print)
Supervisor's Name: Signature Date of Report: / /

(Please Print)
Manager's Name: Signature Date Reviewed / /

The Supervisor will obtain the Manager's signature and forward signed copies of the Employee Report, Witness Statements, and the Supervisor's report, as applicable, to HR.

Appendix H

GENERAL LIABILITY INCIDENT REPORT General Liability Claim #: ______________

Instructions: This report must be turned in within 24 hours of the event.	
Division/Department:	Date of Incident:
Employee Name:	Employee Phone #:
Supervisor:	Supervisor Phone #:

Incident Type:

☐ Gas Meter Issue ☐ Electric Issue ☐ Greenlight issue ☐ Sewer Line issue ☐ Water meter ☐ Street cut

☐ Personal Injury to Citizen ☐ Property Damage to Citizen ☐ City Property Damage ☐ Other: _________________________

*If a Street cut was involved, Supervisor will need to fill out the street cut form

Was a Locate called in before the work was completed: ☐ Yes ☐ No

Incident Information

Incident Location:

Describe what happened and the sequence of events leading up to the incident:

What was the cause of the incident? Did any objects and/or co-workers contribute to the incident?

Describe the Property Damage (What was damaged) :

WILSON NORTH CAROLINA

GENERAL LIABILITY INCIDENT REPORT General Liability Claim #: _______________

Who repaired the Damage (Repaired by City or repaired by an outside contractor:	
Action taken or to be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)	
Additional Information	
Others involved (If more than one, use back of form for additional information	
Property/Vehicle Owner Name: Address: Phone #:	Witness Name: Address: Phone #:
Other Employees Involved Name: Department: Address: Phone #:	Other employees involved Name: Department: Address: Phone #:
I hereby certify that the information I have provided is true and accurate. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.	
Employees Signature	Date of Report: / /
Supervisors Name:	Date Reviewed: / /
Supervisors Signature	

Appendix I

WILSON NORTH CAROLINA

Street Cut Claim Form **Claim # ______________**

Event/Incident Information

Location: ____

Department Responsible: ______________________________

Reason for Street Cut: ____

Date of Street Cut: _______________________ Time Street Cut Occurred: ____________________

Date work was finished: ___________________

Date Street Cut was turned over to Street Department: ___________________________

Maintenance of Cut

Screenings Added

Truck # & Crew: __________________________________ Date: _______________Time: _____________

Truck # & Crew: __________________________________ Date: _______________Time: _____________

Truck # & Crew: __________________________________ Date: _______________Time: _____________

Truck # & Crew: __________________________________ Date: _______________Time: _____________

Truck # & Crew: __________________________________ Date: _______________Time: _____________

Cold Patch Used: Yes____ No _____

Supervisor Name: _______________________________________

Supervisor Signature: ____________________________________ Date: _______________________

** Please attach any other paperwork available in addition to above form