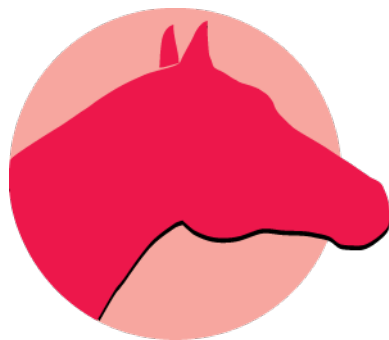


Safety Committees at Racetracks



Moderator: Mike Ziegler

Panelist:

Chip Bach – Turfway Park

Dr. Jerry Pack – Penn National

Roy Roenbeck – Golden Gate Fields

John Wayne – Delaware Commission



Near Miss Committee



Golden Gate Fields
(Berkeley, CA)



Documenting “Near Miss” Incidents/Accidents

- For employee “close calls” & incidents/accidents not requiring medical treatment (first aid okay)
- Uses “Employee Accident Report” form
- Filled-out by employee (in presence of supervisor/manager) as soon as possible
- Includes an incident/accident description as well causation & means for future prevention
- “Waiver of Medical Treatment” clause preserves employee right for future treatment

“Employee Accident Report”

(to be used for documenting employee *Near Miss* incidents)



Employee Accident Report

TO BE COMPLETED BY EMPLOYEE FOR THEIR INJURIES AND NEAR MISSES

Your Name (Injured Employee):		Gender: Male Female	Contact Phone Number:
What is your injury? (Sprained right ankle. Cut left index finger, etc.)			
Where and how did injury occur? (Tripped on bunched up rug in the operations department, sliced finger with knife while chopping vegetables in kitchen, etc.)			
Why did accident happen? (Rug does not grip floor and it bunches whenever someone walks on it, wasn't paying attention while chopping vegetables, etc.)			
How was accident preventable? (Rug could have been reported as dangerous and fixed, I could have been more aware of what I was doing, etc.)			
Report Date:	Injury/Accident Date:	Injury/Accident Time:	Injury/ Accident Reported To: (Name of Manager or Supervisor)
If there was a delay in reporting the accident to a supervisor or a delay in completing this paperwork, please explain:			
Employee Witnesses: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Witness Name:		Witness Name:	

I DECLARE UNDER THE PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT THE FOREGOING IS TRUE AND CORRECT. EXECUTED ON THE _____ DAY OF _____, 20____.

Employee Signature _____

If you feel medical treatment is not necessary, please complete the waiver of medical treatment at the bottom of this form. Signing the waiver relates to the need for medical treatment now, it does not prevent any additional treatment later, if necessary.

WAIVER OF MEDICAL TREATMENT

After completing this report, I declare that medical treatment is not necessary and I elect not to receive medical treatment at this time for this injury. If I choose to seek medical treatment later, I must obtain a Treatment Authorization Form from the manager I reported the injury to.

Employee Signature _____

Date _____

REV APR 2013



Informe de Accidente de un Empleado

PARA SER COMPLETADO POR EL EMPLEADO POR SUS LESIONES Y CUASI-LESIONES

Su nombre (Empleado lesionado):		Genero: Masculino Femenino	Número telefónico:
¿Cuál es su lesión? (me torcí el tobillo derecho, me corté el dedo índice izquierdo, etc.)			
¿Dónde y cómo ocurrió la lesión? (tropecé sobre una alfombra levantada en el departamento de operaciones, me corté el dedo con un cuchillo mientras picaba las verduras en la cocina, etc.)			
¿Por qué ocurrió el accidente? (la alfombra no está adherida al piso y se levanta cuando alguien la pisa, no estaba prestando atención mientras picaba las verduras, etc.)			
¿Cómo podría haber sido prevenido el accidente? (la alfombra podría haberse declarado peligrosa y haberse arreglado, yo podría haber prestado mayor atención a lo que hacía, etc.)			
Fecha del informe:	Fecha de la lesión/accidente:	Hora de la lesión/accidente:	Lesión/accidente informado a: (nombre del Gerente o Supervisor)
Si hubo demora en informar acerca del accidente a un supervisor o demora en completar este papel, por favor explique:			
Testigos del empleado: <input type="checkbox"/> Sí <input type="checkbox"/> No			
Nombre de un testigo:		Nombre de un testigo:	

DECLARO BAJO PENA DE FALSO TESTIMONIO, BAJO LAS LEYES DEL ESTADO DE CALIFORNIA, QUE LO QUE PRECEDE ES VERDADERO Y CORRECTO. FIRMADO EN EL _____ DÍA DE _____, 20____.

Firma del empleado _____

Si cree que el tratamiento médico no es necesario, por favor complete la renuncia a tratamiento médico al final de este formulario. Firmar la renuncia se relaciona con la necesidad de tratamiento ahora, no impide el tratamiento adicional más tarde, de ser necesario.

RENUNCIA A TRATAMIENTO MÉDICO

Luego de completar este informe, declaro que el tratamiento médico no es necesario y elijo no recibir tratamiento médico en este momento para esta lesión. Si decido buscar tratamiento médico más tarde, debo obtener una Autorización para Tratamiento del gerente al que le informé sobre la lesión.

Firma del empleado _____

Fecha _____

REV ABR 2013



Value of a “Near Miss” Program

- Serves as a “warning” of potential future repeat incidents (*can also trigger “work orders” to mitigate the underlying risk/hazard*)
- Documents the particulars of an incident/accident (*in case of later injury detail discrepancies*)
- Provides a “placeholder” for any future WC Claim (*avoiding insurance questions of legitimacy*)
- Serves to formalize the on-site WC “accident reporting & investigation” process at the facility and allows “information sharing” between depts.