



**THE CITY OF NEW YORK
DEPARTMENT OF SANITATION
GENERAL ORDER 2017-02**

EFFECTIVE DATE: January 9, 2017

SUBJECT: **PROCEDURES FOR UNIFORMED EMPLOYEES
REPORTING AND ELECTRONICALLY RECORDING
A LINE OF DUTY INJURY (LODI)**

AFFECTED DIRECTIVES: General Order 2012-20 is hereby cancelled.

REFERENCE: G.O. 2007-04 Medical Leave Control

**PROCEDURES FOR UNIFORMED EMPLOYEES CLAIMING A LINE OF DUTY
INJURY (LODI):**

The Supervisor's Responsibilities:

1. Upon being notified of and/or observing a LODI, immediate efforts will be made to evaluate the situation and for the injured employee to be brought to the nearest hospital for treatment. The emergency contact person(s) on file, on the DS 379 Personal Record Card, will be notified and given all pertinent details unless they were informed by the injured employee, or the employee elects to not have them notified. If a family member or emergency contact is not notified the supervisor must document this in the Unusual Incident Report (DS 779). In the event the injured employee has not been treated and released by the end of their shift, the emergency contact or a family member must be notified of their status. The investigating supervisor will provide a DS 807B (Appendix A) to the injured employee. **Supervisors do not have authority to permit an injured employee to continue working.** Borough or Unit locations must immediately be notified of the occurrence. Boroughs/Units will inform the Bureau Operations Office and an Unusual Incident (DS779) will be sent through channels in a timely manner, Email to unusual823@dsny.nyc.gov. Borough staff emailing the LODI unusual should follow-up with the Officer on Duty in Operations to confirm receipt of the unusual incident report and provide any additional information.

Investigating supervisors are required to complete the electronic DS 807 which is accessible from the DSNY Intranet page (Appendix B), under the DSNY Manuals banner by logging in with their personal password. Investigating supervisor must ensure completeness of section 1, then print out the form to have sections 2 and 3, completed and signed by all parties involved. Upon completion of sections 1, 2, and 3 with

necessary signatures, the form needs to be uploaded into the LODI tracking system for further processing. In the event an injured employee is unable to provide a hand written statement the Investigating Supervisor should get a verbal statement of how the LODI occurred, record it in section-2 and initial below the statement. **Blank DS 807 (Appendix C) and DS 807B paper forms must be kept in Supervisor's possession.** DS 807 paper forms will be used when online access to the digital form is unavailable. **The DS 807 and DS 807B must be completed within 24 hours.**

2. The Supervisor shall inform the injured employee that it is **his or her responsibility** to establish the claim of line-of-duty injury or illness by first having the attending physician at the hospital complete the DS 807B. He or she must bring it with them and submit it to the DSNY Health Care Facility (HCF) upon their first visit for the LODI.
3. The Supervisor shall inform injured employee that, unless hospitalized, they must report to the DSNY HCF with the completed DS 807B and a copy of the DS 807, with Sections 1,2, and 3 completed, the next day (unless otherwise noted on DS 807B or If the employee is injured on a Friday, Saturday, day prior to a holiday, or on a holiday, employee must report to the DSNY HCF the next calendar day that the DSNY HCF is open). Instruct employee, if he or she is not hospitalized and is medically incapable of reporting to the DSNY HCF, they must contact a HCF supervisor at 212-437-4848, or 4821.
4. The Supervisor shall prepare and distribute the following forms as indicated:
DS 807B: For injured employee to have filled out by attending Physician at the hospital and bring to the DSNY Medical Division- HCF

DS 807: One copy given to injured employee to bring to the DSNY HCF.

5. If the injured employee has not been treated and released by the end of the shift in which they were injured, the emergency contact or a family member must be notified of their status. The emergency contact will also be advised on the DSNY emergency transportation protocol (refer to General Order 2007-04). In the event an employee is hospitalized, a supervisor should attempt to secure the 807B, or equivalent document, from the hospital and submit it directly to:

NYC Department of Sanitation
Medical Division – HCF
44 Beaver Street
New York, NY 10004

Supervisors must also call the DSNY HCF, Hospitalization Unit, at 212-437-4831 to inform the Medical Division that an employee has been admitted to a hospital.

6. In case the electronic DS 807 is not accessible due to a power outage or a lack of internet access, the paper DS 807 will be utilized. Sections 1, 2 and 3 will be completed and signed and a copy given to the injured employee which they must bring to the DSNY-HCF. The form will then be processed by the District Superintendent and forwarded to Operations through proper channels with a paper copy being kept at each level.

One copy is to be kept at the injured employee's payroll location. Upon the digital DS 807 becoming available, the information contained on paper will be entered into the online system with the original document being scanned and uploaded for record keeping.

7. If the injured employee is not payroll assigned to the location in which the LODI occurred and is being processed, the investigating Supervisor shall notify the payroll location to insure the correct entries are made into HRMS and other record keeping.

Injured Employees Responsibilities:

In order to claim an injury/ illness as LODI, the employee making the claim must:

1. Notify work location supervisor immediately. Employee will be provided with a DS 807B to be filled out by attending Physician at the hospital.

ANY EMPLOYEE CLAIMING A LODI AT ANY TIME OTHER THAN ON THE DATE OF THE INJURY DURING THEIR SCHEDULED SHIFT WILL BE CARRIED SICK, NOT LODI!

2. Be transported to the nearest hospital for medical evaluation and/ or treatment and have the DS 807B form completed by the attending doctor.
3. The injured employee will provide a handwritten statement to be entered onto the printed DS 807 form (section 2). Upon completion of Sections 1, 2, and 3, with signatures from the investigating supervisor, injured employee, and witnesses, respectively, the investigating supervisor will scan and upload the DS 807 into the electronic tracking system and give a paper copy to the injured employee. Employees must submit the copy of the DS 807 and a DS 807 B to the DSNY Health Care Facility (HCF) sign-in window upon their first visit.
4. Injured employee must follow instructions as directed on the DS 807B with regard to reporting to the DSNY HFC. If an employee is not hospitalized, but feels he or she is medically incapable of reporting to the DSNY HCF, the employee must call the DSNY HCF to speak to a supervisor at 212-437-4848 or 212-437-4821. If the employee is injured on a Friday, Saturday, day prior to a holiday, or on a holiday, employee must report to the DSNY HCF the next calendar day that the HCF is open.

Except in the case of a life threatening emergency, employees must report to the DSNY HCF to receive prior medical authorization before seeking additional treatment (beyond that of the original emergency room evaluation, emergency treatment, or emergency admission to the hospital). Reporting to the HCF is also necessary before being authorized to resume regular or limited duty.

District Superintendent /Borough Operations Supt. Responsibilities:

1. Both the District Superintendent and the B.O.S will log into PeopleSoft twice daily (once in the beginning and once toward the end of the shift) to check on the status of any Pending LODI's that are in the system needing their approval.

2. District Superintendent reviews signed DS 807 and online attachments, adds comment, and certifies its completeness by initialing online.
3. BOS reviews uploaded signed forms and attachments and DS comments and certifies its completeness by initialing online.
4. Upon BOS approval and completion of the workflow status, the system generates an email to Medical Billing Unit advising of the completed status.

In the event of the digital system not being available, when the workflow status is **Completed**, the DS 807 form needs to be scanned and uploaded with attachments (DS 807B, photos, etc.) and sent via e-mail as attachments to : LODIDS807@DSNY.NYC.GOV. The subject line should be: LODI DS 807 – [reference number].

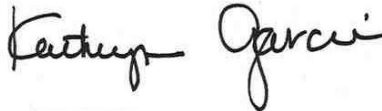
5. In the absence of the B.O.S. or the regular approving officer the Deputy Chief in Charge of the Work Unit/Location will approve the DS 807 as completed.

Is it the Location Supervisor's responsibility to ensure that all pertinent sections of this General Order are brought to the attention of all personnel under his or her command.

CANCELLATION:

This Order shall remain in effect until it is cancelled.

ISSUING AUTHORITY:



Kathryn Garcia
Commissioner

DISTRIBUTION:

All Management Personnel.

APPENDIX "A"

sanitation

LINE OF DUTY INJURY / MEDICAL REPORT DS 807B (7-11)

DATE

DATE OF ALLEGED INJURY

ATTENTION: If this form is not completely filled out the Department of Sanitation will not make payment for services rendered Also, employee may not be paid because of lack of medical documentation.

I hereby authorized that this medical record be sent to the NYC Department of Sanitation.

EMPLOYEE'S SIGNATURE

TO BE FILLED OUT BY FACILITY

NAME OF HOSPITAL / EMERGENCY FACILITY

NAME OF PHYSICIAN (PRINT)

NAME OF PATIENT (PRINT)

REFERENCE NO. / SOC. SEC. NO. (LAST 4 DIGITS)

TO BE FILLED OUT BY PHYSICIAN

SUBJECTIVE COMPLAINT:

SIGNIFICANT PERTINENT HISTORY:

TESTS OR EXAMINATION DONE (RESULTS IF AVAILABLE):

CLINICAL

OBJECTIVE FINDINGS:

MEDICAL DIAGNOSIS:

TREATMENT:

CAN THIS BE SUBSTANTIATED AS A NEW INJURY?

YES

NO

PLEASE CHECK ONLY ONE OF THE FOLLOWING

- 1. No significant to minimal findings: employee capable of reporting to the Department of Sanitation Clinic **IMMEDIATELY**, (If Clinic is closed, then report next working day at 0700 hrs.)
- 2. Employee is capable of reporting to the Department of Sanitation Clinic tomorrow for physical assessment, (If Clinic is closed, then report next working day at 0700 hrs.)
- 3. Employee requires further treatment and can not report to the Department of Sanitation Clinic at this time. Employee can travel to the DSNY Clinic _____. Employee must call the Clinic immediately for instructions (212-437-4821/48) upon release from the hospital or treating facility.
- 4. Employee requires immediate hospitalization.

PLEASE CHECK APPROPRIATE BOX

- A. EMPLOYEE HAS NO CONTRA-INDICATION FOR UNDERGOING SUBSTANCE ABUSE TESTING AT THIS TIME.
- B. EMPLOYEE IS PHYSICALLY UNABLE TO UNDERGO A SUBSTANCE ABUSE TESTING (U.T.) AT THIS TIME.

Reason unable to test _____

SIGNATURE OF EXAMINING PHYSICIAN

TITLE

DATE

FOR SUPERVISOR'S USE ONLY (PRINT)

EMPLOYEE'S NAME

BADGE NO.

REF NO. / SOC. SEC. NO. (LAST 4 DIGITS)

PAYROLL DISTRICT

LOCATION

NAME OF PERSON WHO ACCOMPANIED INJURED EMPLOYEE TO EMERGENCY FACILITY

DATE TOLD TO REPORT TO CLINIC

SUPERVISOR'S NAME

NOTE: This form must be brought to Clinic by injured employee on first Clinic visit.

APPENDIX "B"

New York City Department of Sanitation (DSNY)



DS 807 LODI Form

Access from the DSNY Intranet Home Page

DSNY MANUALS, MAPS AND FORMS

DSNY Manual (cscuser)
DS 807 LODI

DSNY PEOPLESOFT HR - Production Login

Username is full email address in **all CAPS** for Log In

User ID DBEAVER@DSNY.

Password

Sign In

Password is same as used for SMART/BladeRunner/Network

Attachments - to attach the witness and employee statements and any other supporting documents

Investigating Supervisor | Attachments

Incident Number: NEW Workflow Status: Started LODI-Help Return to Search

Attached File	Type	Comments	Created By	Created Datetime	Add	View	Download
1							

Save Previous tab Next tab

Investigating Supervisor | Attachments

LODI Notes for Attachments

Incident Number: NEW

*Type:

*Status:

*File: Browse

*Comments:

Attach Cancel



New York City Department of Sanitation (DSNY)

Investigating Supervisor | Attachments | LODI-Help | Return to Search

Section1-To be completed by the Investigating Supervisor

Supervisor: Check here if incident involved a moving vehicle | Workflow Status: Started

Incident Number: NEW | *Incident Date: 10/14/2016 | *Incident Hour: | *Min: |

*Injured Employee Ref#: | Injured Employee's Name: | Title: |

Appointment Date: | Age Years: | *Employee's Shift: |

Location where Incident Occurred

Borough: | *Incident Location Exact Street Name(s): |

Injured Employee's Payroll Location

Borough: | District: | Section: |

Work Location On Day of Incident

Same as Payroll Location | [Click here to view all Units and Locations hierarchy](#)

Borough/Unit: | District/Location: | Section: |

Payroll Supervisor Information

*Payroll Supervisor Ref#: | Payroll Supervisor Name: | *Phone: () - |

Borough: | District: |

How was injured employee transported to the Hospital?

Type of Transport: | If ambulance, what was the number? |

Name of EMT: | EMT Badge Number: |

Hospital Information

Hospital: | Hospital's Address: |

Attending Physician's Name: | Hospital Phone: () - | Extension: |

Injured Employee Information

*Type of Work Assigned: |

Injured Part of Body Find First 1 of 1 Last

Injured part of Body: |

Nature of Injury Find First 1 of 1 Last

Nature of Injury: |

Nature of Injury Find First 1 of 1 Last

Nature of Injury: |

Incident Type Find First 1 of 1 Last

Type of Incident: |

Unsafe Act Find First 1 of 1 Last

Type Of Unsafe Act: |

Unsafe Condition Find First 1 of 1 Last

Type Of Unsafe Condition: |

Did injured employee continue to work? | Was the incident witnessed by a Supervisor? |

Was medical care provided immediately? |

Has employee been injured in the past 12 months? |

Did the incident occur while entering/exiting the vehicle? | Was employee coming off of a night shift? |

Was employee driving from right side of vehicle? | Was employee working "out of town"? |

Was employee wearing protective vest? | Was employee wearing uniform shorts? |

Was employee wearing protective gloves? | Was employee wearing long sleeves? |

Was employee wearing protective footwear? | Did incident occur during performance of duty? |

Was incident investigated by Safety Division? |

If incident resulted from unsafe condition, what corrective action was taken? |

250 characters remaining

If incident resulted from unsafe action, what discussion took place with employee? |

250 characters remaining

Investigating Officer Information

Same as Payroll Supervisor

Officer's Reference Number: | Investigating Officer's Name: |

Borough: | District: | Section: |

Save | Previous tab | Next tab

The DS807 LODI Form



Favorites Main Menu > Workforce Monitoring > Health and Safety > DS 807 LODI

Investigating Supervisor Injured Employee & Witnesses Superintendent & BOS Attachments Medical Billing

Incident Number: 1516533-07112016

Workflow Status: Pending BOS Review

LODI-Help

Return to Search

Section 4 - Supt

Superintendent's comments:

Characters remaining 250

Text input area for Superintendent's comments

By initialing, I certify that the online DS 807 to my knowledge is now complete and the uploaded form has the required signatures and is ready for BOS review.

By initialing, I have reviewed the DS 807 and uploaded forms and have determined they need to be revised or completed.

Superintendent's Reference Number: 0014134

Superintendent's Name: Lazare, Peter F

Date: 07/14/2016

Borough: MNBO

District: MN02

Section:

Borough Operations Superintendent page - initials entered for approval

Section 5 - Borough Operations Superintendent

By initialing, I certify that the online DS 807 to my knowledge is now complete and the uploaded form has the required signatures and is ready for Medical's review.

By initialing, I have reviewed the DS 807 and uploaded forms and have determined they need to be revised or completed.

BOS Reference Number:

BOS Name:

Date:

Generate PDF to Print

Generate PDF

Save Previous tab Next tab

Investigating Supervisor | Injured Employee & Witnesses | Superintendent & BOS | Attachments | Medical Billing

APPENDIX "C"

DETACH THIS COVER SHEET BEFORE STARTING TO WRITE

Underline the proper descriptive statement and its corresponding code number, where applicable, for each of the categories below. After the numbers are entered in the proper place on the form, the immediate supervisor on duty at the time of injury must complete a written statement explaining the incident, using these categories:

INJURED PART OF BODY

U1	FINGER	L1	TOE	H1	HEAD
U2	HAND	L2	FOOT	H2	FACE
U3	WRIST	L3	ANKL	H3	EYE
U4	ARM	L4	LEG	H4	EAR
U5	ELBOW	L5	KNEE	H5	NOSE
				H6	MOUTH
				H7	TEETH

INJURED SIDE(S) OF BODY

11	GROIN	LEFT
12	LUNGS	RIGHT
0D	OTHER	BOTH

NATURE OF INJURY

N 1	AMPUTATION	N 8	DISLOCATION	N 15	SCRATCHES (Superficial Wounds	N 0	OTHER
N 2	ASPHYXIA	N 9	ELECTRIC SHOCK	N 16	SPRAINS, STRAINS		
N 3	BURN OR SCALD	N 10	FRACTURE	N 17	MULTIPLE INJURIES		
N 4	CONCUSSION	N 11	FOREIGN BODY	N 18	HEATING LOSS		
N 5	CONTUSION, CRUSHING, BR	N 12	HEAT STROKE	N 19	VISION LOSS		
N 6	CUT, LACERATION	N 13	HERNIA	N 20	INHALATION OF FUMES		
N 7	DERMATITIS	N 14	INFECTION	N 21	PUNCTURE, NEEDLESTICKS		

INCIDENT TYPE

AT 1	STRUCK AGAINST STATIONARY TRUCK	AT 9	BODILY REACTION FROM VOLUNTARY MOTION
AT 2	STRUCK AGAINST MOVING OBJECT	AT 10	OVER EXERTION
AT 3	STRUCK BY FALLING OBJECT	AT 12	CONTACT WITH NOXIOUS FUMES
AT 4	STRUCK BY FLYING OBJECT	AT 13	VEHICLE ACCIDENT OVER EXERTION
AT 5	FALL FROM ELEVATION	AT 14	ANIMAL, INSECT BITE
AT 6	FALL ON SAME LEVEL	AT 15	ASSAULT
AT 7	CAUGHT IN, UNDER OR BETWEEN	AT 16	LIQUID, SLIPPERY SUBSTANCE
AT 8	RUBBED OR ABRADED	AT 0	OTHER (Specify type of incident)

UNSAFE ACT

A 1	OPERATING WITHOUT AUTHORITY
A 2	OPERATING WITHOUT OR WORKING AT UNSAFE SPEED (too fast, too slow, unsafe short cuts)
A 3	MAKING SAFETY DEVICES INOPERATIVE (bypassing, disconnecting, misadjusting, etc.)
A 4	USING UNSAFE EQUIPMENT OR USING EQUIPMENT UNSAFELY
A 5	UNSAFE LOADING, PLACING MIXING, COMBINING
A 6	TAKING UNSAFE POSITION OR POSTURE (improper lifting, twisting body, in right of way or line of travel, etc.)
A 7	WORKING ON MOVING OR DANGEROUS EQUIPMENT UNNECESSARILY (oiling, cleaning, adjusting, etc.)
A 8	HORSEPLAY (teasing, fooling, practical joking, quarreling, distracting, etc.)
A 9	FAILURE TO WEAR PERSONAL PROTECTIVE DEVICES (such as goggles, gloves, safety shoes, respirators, etc.)
A 10	OTHER UNSAFE ACT (Specify in additional remarks section of the form)
A 11	N/A

UNSAFE CONDITION

C 1	INADEQUATELY GUARDED (flimsy, loose, improper, insufficient, incomplete, etc.)
C 2	UNGUARDED (platforms, catwalks, points of operation, power transmission apparatus, etc.)
C 3	DEFECTIVE TOOLS, EQUIPMENT, SUBSTANCE (worn, torn, cracked, broken, rusty, bent, etc.)
C 4	UNSAFE DESIGN OR CONSTRUCTION (in the blueprint, plan engineering or fabrication)
C 5	HAZARDOUS ARRANGEMENT (poor layout of machines, aisles, exits, congestion or housekeeping)
C 6	UNSAFE ILLUMINATION (lighting too weak, too strong, glare type, direction, color, etc.)
C 7	UNSAFE VENTILATION (concentrations of toxic fumes, vapors, dusts, etc.)
C 8	UNSAFE CLOTHING (for the job being done, inadequate, unsuited, ill fitting, etc.)
C 9	UNSAFE FOOTING OR CONDITION (due to grease, ice, water, debris, obstacle, pothole etc.)
C 10	OTHER (Specify in additional remarks section of the form)
C 11	N/A

SHIFT

2200-0600	0200-1000	0600-1400	1000-1800	1400-2200	1800-0200	Other (Specify Shift)
2300-0700	0300-1100	0700-1500	1100-1900	1500-2300	1900-0300	
0000-0800	0400-1200	0800-1600	1200-2000	1600-0000	2000-0400	
0100-0900	0500-1300	0900-1700	1300-2100	1700-0100	2100-0500	

TYPE OF WORK ASSIGNED

Collection	Mechanical Broom	Wrecker	CFC	School Truck	Snow Melter
Recycling	Plowing	Guide man	Baskets	FEL	Bulk Truck Collection
Relays	Spreading	Roll On/ Roll Off	Transport	Salt Receiving	Other (Specify work)
MLP/Cleaning	Garage Utility	EZ Pack	Security	Salt Loading	

<input type="checkbox"/> Investigating Supervisor : Check here if incident involved a moving vehicle	EMPLOYEE'S REFERENCE NUMBER								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%; height: 20px;"></td> </tr> </table>								

Caution to supervisors, injured employees and witnesses:
 Disciplinary Code Rule 6: Making false reports or entries in or on any Department or other official record or in connection with any Departmental operation or activity will result in disciplinary action.

INSTRUCTIONS:

1. This report must be received by the Medical Division within 48 hours of the incident.
2. The copy of this report must be printed/detached and given to the injured employee immediately upon completion of Sections 1, 2 & 3.
3. Injured employee must submit this form and the DS807B to the HCF Sign-in window within 24 hours.

SECTION 1 - To be completed by the Investigating Supervisor	DATE OF INJURY	TIME OF INJURY	AGE	LOCATION WHERE INCIDENT OCCURRED	BOROUGH	EXACT STREET NAME(S)		
	INJURED EMPLOYEE'S (Last, First, Mi.)			WORK LOCATION ON DAY OF INCIDENT	BOROUGH	DISTRICT	SECTION	
	TITLE	APPOINTMENT DATE	INJURED EMPLOYEE'S PAYROLL LOCATION		BOROUGH	DISTRICT	SECTION	
	PAYROLL SUPERVISOR'S NAME			SUP. REF. NUM.	BOROUGH	DISTRICT	SUPERVISOR PHONE	
	EMPLOYEE'S SHIFT	TYPE OF TRANSPORT	IF AMBULANCE, WHAT WAS THE NUMBER?		NAME OF EMT		EMT BADGE NUMBER	
	NAME OF HOSPITAL	HOSPITAL'S ADDRESS			ATTENDING PHYSICIAN'S NAME		HOSPITAL PHONE	
	TYPE OF WORK ASSIGNED			INJURED SIDE(S)	INJURED PART OF BODY			
	NATURE OF INJURY	TYPE OF INCIDENT	TYPE OF UNSAFE ACT		TYPE OF UNSAFE CONDITION			
	Additional remarks on any information not covered above; be specific							
	DID INJURED EMPLOYEE CONTINUE TO WORK?				WAS MEDICAL CARE PROVIDED IMMEDIATELY? If 'No' give Date:			
	DID INCIDENT OCCUR DURING PERFORMANCE OF DUTY?				WAS INCIDENT INVESTIGATED BY SAFETY DIVISION? If 'yes' give Date: Time:			
	HAS EMPLOYEE BEEN INJURED IN THE PAST 12 MONTHS?				IF YES, IS THIS THE SAME INJURY TYPE?			
	WAS EMPLOYEE COMING OFF OF A NIGHT SHIFT?				WAS EMPLOYEE WEARING LONG SLEEVES?			
	WAS THE INCIDENT WITNESSED BY A SUPERVISOR?				WAS EMPLOYEE WEARING PROTECTIVE VEST?			
	WAS EMPLOYEE WORKING 'OUT OF TOWN'?				WAS EMPLOYEE WEARING UNIFORM SHORTS?			
DID THE INCIDENT OCCUR WHILE ENTERING/EXITING THE VEHICLE?				WAS EMPLOYEE WEARING PROTECTIVE GLOVES?				
WAS EMPLOYEE DRIVING FROM RIGHT SIDE OF VEHICLE?				WAS EMPLOYEE WEARING PROTECTIVE FOOTWEAR?				
If incident resulted from unsafe condition, what corrective action was taken?								
If incident resulted from unsafe action, what discussion took place with employee?								
INVESTIGATING OFFICER			BOROUGH	DISTRICT	SECTION	INVESTIGATING OFFICER'S SIGNATURE	DATE	
INVESTIGATING OFFICER'S REF. NUM.								

SECTION 2 - Injured Employee	Injured employee's own description of the incident, including part of body affected, and circumstances surrounding the incident						
	How could the injury have been prevented?						
	HAVE YOU BEEN INJURED IN THE PAST?	NUMBER OF TIMES INJURED		INJURED EMPLOYEE'S SIGNATURE		DATE	

SECTION 3 - Witnesses	Statement of 1 st eyewitness						
	1 st EYEWITNESS NAME	ADDRESS			1 st EYEWITNESS SIGNATURE		DATE
	Statement of 2 nd eyewitness						
	2 nd EYEWITNESS NAME	ADDRESS			2 nd EYEWITNESS SIGNATURE		DATE

SECTION 4 - Supt.	District Superintendent's comments						
	SUPERINTENDENT NAME	SUPT. REF. NUM.		BOROUGH	DISTRICT	DATE	
	<input type="checkbox"/> By initialing, I certify that the online DS 807 to my knowledge is now complete and the uploaded form has the required signatures and is ready for BOS review.						

SECTION 5 - BOS	BOROUGH OPERATIONS SUPT. NAME	BOS. REF. NUM.	DATE
	<input type="checkbox"/> By initialing, I certify that the online DS 807 to my knowledge is now complete and the uploaded form has the required signatures and is ready for Medical's review.		