INSTRUCTION SHEET FOR THE CITY OF PHILADELPHIA ACCIDENT, INJURY & ILLNESS (COPA II) REPORT

COMPLETE ALL SECTIONS OF THIS REPORT. FORMS WITH MISSING OR INCOMPLETE INFORMATION WILL BE RETURNED.

IT IS RECOMMENDED THAT THE SUPERVISOR AND INJURED EMPLOYEE COMPLETE THIS FORM JOINTLY.
HOWEVER, **THE SUPERVISOR IS ULTIMATELY RESPONSIBLE FOR THE COMPLETION OF THIS FORM**.

1. **Name:** Enter employee's last name, first name and middle initial (if applicable).
2. **Present Address:** Enter employee's most current address
3. **Occurrence Type:** Select one of the three options - Injury in the event medical treatment or first aid has been provided due to an instantaneous event; Illness in the event medical treatment or first aid has been provided due to repeated exposure; or Near-Miss if no injury or illness occurred, but hazardous conditions existed that could have caused an injury or illness.
4. **Gender:** Select male or female.
5. **Employee Phone Numbers:** List employee's home, work, and/or cell numbers.
6. **Department & Division:** Enter employee's department and division.
7. **Normal Unit/District:** Enter employee's normal unit and/or district.
8. **Payroll No.:** Enter employee's payroll number.
9. **Work Status:** Select one of the four options - Full-Time, Part-Time, Seasonal or Temporary.
10. **Current Job Title:** Enter employee's current job title.
11. **Job Title at Time of Injury:** Enter the job being performed by the employee at the time of the injury/illness.
12. **Work Assignment:** Select one of the three options - Routine, Non-Routine (either "out of job class" or "not everyday job"), or Emergency.
13. **Immediate Supervisor & Phone Number:** Enter the employee's regular supervisor and their phone number.
14. **Immediate Supervisor on Duty at Time of Injury:** Enter the supervisor on duty at the time of the injury.
15. **Witnesses:** List the witness' last name, first name and middle initial (if applicable), telephone number, and job title if employed by the City of Philadelphia. Use additional sheets if needed.
16. **Date of Injury:** Enter the date of injury in MM/DD/YYYY format.
17. **Time of Injury:** List the exact time of the injury and then select AM or PM.
18. **Date Injury Reported:** Enter the date the injury was reported by the employee to the appropriate supervisor, using MM/DD/YYYY format.
19. **Time Injury Reported:** List the exact time that the injury was reported and then select AM or PM.
20. **Usual/Normal Work Hours?:** Check yes if the injury occurred during the employee's usual or normal work hours, or check no if not. Checking yes means that 21 will be checked no, and vice versa.
21. **Overtime Shift?:** Check yes if the injury occurred during overtime, or check no if not.
22. **Straight Shift?:** Check yes if the injury occurred during a straight shift, or check no if not. Checking yes means that 23 will be checked no, and vice versa.
23. **Rotating Shift?:** Check yes if the injury occurred during a rotating shift, or check no if not.
24. **Injury Occurred INSIDE:** Check only if the injury/illness occurred inside a building or facility. If injury occurred inside, complete 25-26. If injury occurred outside, skip to 27.
25. **Address & Building Name:** List compete street address with city, state and zip code.
26. **Exact Location:** List the floor (2nd, 3rd, etc.) and work area; be specific.
27. **Injury Occurred OUTSIDE:** Check only if the illness/injury occurred outside - on the street, in a yard, park, etc. If injury occurred outside, complete 28-29. If injury occurred inside, skip to 30.
28. **Location - Intersection:** Enter the exact intersection where the injury/illness occurred. If the injury/illness did not occur at an exact intersection, list the nearest intersection instead. Then, estimate the # of feet and the direction (north, south, east or west) from that intersection.
29. **Outside Normal Work Area/District?:** Check yes if the incident occurred outside the employee's normal work area or district, and then enter the area/district in which the incident occurred. Check no if the incident occurred within the employee's normal geographic work area or district.
30. **Accident Type:** Check only one box, or check other and enter the type of accident.
31. **Body Part(s) Injured:** Check the body part(s) injured. For each body part checked, specify front (F) and/or back (B) and left (L) and/or right (R) in the adjacent fields.
32. **Describe Exactly What Happened:** Describe the incident in detail. List all equipment, materials, etc. Use additional sheets if needed.
33. **Medical Treatment & Initial Treatment Date:** Select only one of the four options. If First Aid, specify date and type of first aid administered (plastic bandage, ice pack, etc.). If City Medical Provider or Other, specify date and site.
34. **D.C. Number:** If applicable, fill in the D.C. number from the traffic accident form.
35. **A.I.D. Number:** If applicable, fill in the A.I.D. case number from the traffic accident form.
36. **Vehicle Property No.:** If applicable, fill in the vehicle property number from the traffic accident form.
37. **Employee Signature:** Employee signs here.
38. **Date:** Enter date in MM/DD/YYYY format.
39. **Immediate Supervisor on Duty Signature:** Immediate supervisor on duty at time of injury signs here.
40. **Date:** Enter date in MM/DD/YYYY format.
41. **Unit Supervisor Signature:** Unit supervisor signs here.
42. **Date:** Enter date in MM/DD/YYYY format.
43. **Dept. Safety Officer Representative Signature:** Dept. safety officer representative signs here.
44. **Date:** Enter date in MM/DD/YYYY format.
45. **For D.C. 47 Employees Only:** Initialing and dating here permits release of report information to the Health and Safety Office of D.C. 47.
46. **Fundamental Causes:** To be completed by immediate supervisor on duty at time of injury. Discuss equipment, environment, people and personal protective equipment (PPE) conditions that may have been present and / or that may have contributed to the injury/illness with the affected employee and any witnesses. Review items A-Y and check ALL that apply.
47. **Corrective Actions:** To be completed by the Immediate or Unit Supervisor. Talk with the injured employee and any witnesses about the appropriate corrective actions associated with each checked condition in section 46. List them in section 51. Please be specific; for example, list a specific piece of equipment, specific safety procedures, and/or specific PPE.
48. **Date Recommendations Implemented:** List the date that the recommended corrective actions were implemented in MM/DD/YYYY format. This date can be forwarded to the Departmental Safety Office after corrective actions are completed, if not done at the time the report was submitted.

SIGNING THIS FORM DOES NOT CONFIRM OR ACKNOWLEDGE AGREEMENT WITH THE INFORMATION LISTED ON THE FORM. SIGNING THE FORM CONFIRMS THAT EVERYONE IS AWARE THAT THE REPORT HAS BEEN COMPLETED PER ITS INSTRUCTIONS.

A SPECIAL NOTE ABOUT ADOBE ACROBAT READER: Users with the free Adobe Reader will be unable to save the completed form to their computer's hard drive. Upon completing the editable portions of this form, users unable to save should print an additional hard copy of the completed form to save for their records.