

Volunteer Injury Instructions

This packet contains information about dealing with injuries suffered by Appalachian Trail and USFS volunteer workers. It should be carried by individual volunteers or work trip leaders. Volunteers carrying this packet should be familiar with its contents.

Emergency: call 911

Nelson County Sheriff: (434) 263-7050 or 800-750-5757

This packet includes:

- A.T. Volunteer Injury or Near Miss Instructions (4 pages)
- Form CA-1 – Federal Employee’s Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (2 pages)
- Maps to nearest Hospital Emergency Rooms and to Urgent Care Centers
- Emergency Response Plan
- ATC - Incidents: What to do when...

If an injury or near miss occurs; follow the steps shown on the first page of the A.T. Volunteer Injury or Near Miss Instructions

Land Manager Contacts

USFS Glenwood-Pedlar Ranger District Contact: Plinio Beres, Volunteer Coordinator, (540) 291-2188 (daytime), (540) 795-9510 (gov. cell), plinio.beres@usda.gov or Lauren Stull, District Ranger, (540) 291-2188 (day time), (540) 460-3855 (gov. cell), lauren.stull@usda.gov

NPS Blue Ridge Parkway Emergency Contact: Jonathan Howard Bennett, Volunteer Program Manager, (828) 348-3424 (Office), (828) 772-7588 (Government Mobile), Jonathan_Bennett@nps.gov

NPS-APPA Chief Ranger: Ed Clark, (540) 784-0301, Ed_W_Clark@nps.gov, After-hours NPS dispatch line: 1-866-677-6677

Nearest Hospital Emergency Rooms:

Augusta Medical Center

78 Medical Center Dr.
Fishersville, VA 22939
(540) 932-4444

<https://www.augustahealth.com/service/emergency-department/>

Distance from Reids Gap - 19.2 miles

Distance from Tye River Parking Lot – 32.1 miles

what3words.com - ///prime.fascinate.belonging

University Hospital

1215 Lee St.
Charlottesville, VA 22908
(434) 924-2231
(434) 924-9295 Fax
<https://uvahealth.com/locations/Emergency-Department-5597289>

Distance from Reids Gap - 38 miles

Distance from Tye River Parking Lot – 48 miles

what3words.com - ///beats.snack.supper

A.T. Volunteer Injury or Near Miss Flow Chart

Start here: Choose Left for Volunteer Injury or Right for Close Call



Is Urgent Medical Care Needed?



Complete the A.T. Volunteer Injury / Near Miss Form. (Seek medical attention if needed.)

Seek Medical Care

Try to complete the A.T. Volunteer Injury / Near Miss Form while memory is fresh
- or ask for help to complete it. Regardless, proceed to next step.

ASAP and no more than 24 hours later, call land manager or Trail Supervisor for help contacting the land manager, so that the CA-1 form can be completed. Take any steps as instructed by land manager.

Everyone's OK: it was a Close Call or a Near Miss!



Complete the Volunteer Injury / Near Miss Form



Send a scan or photo of the Volunteer Injury / Near Miss Form to volunteer@appalachiantrail.org

If you plan to or may seek a claim for worker's compensation, request that the land manager send a CA-16 to the medical facility.

(flip page for form)

A.T. Volunteer Injury/Near Miss Report



Injured Volunteer Data:			
1. Full Name (Last, First, Middle)	2. Last 4 Digits of Social Security Number:		
3. Date of Birth (MM/DD/YYYY):	4. Gender:	5. Phone: () -	
7. Mailing Address (Street): City, State, Zip:	6. Is someone other than an injured volunteer completing this? If yes, provide name and contact information: (Last Name, First Name): Email: Phone: () -		
8. Email Address:			
Description of Incident			
9. Location where injury or near miss occurred (describe for another to navigate there, e.g. the facility name or X mi N/S from Y road):			
10. Date of incident (MM/DD/YYYY):	Time of incident (AM/PM):	11. Date of Reporting (MM/DD/YYYY):	12. Club or Affiliation:
13. Cause (or near cause) of injury (describe what happened, which volunteer activity the person was undertaking at the time, and why):			
14. Nature of injury (identify both the injury & the part of the body)		<input type="checkbox"/> If no injury: check box for near miss	
15. Individuals will be asked to affirm that the injury was sustained in the performance of duty, not caused by misconduct, intent to injure self/others, nor due to intoxication.			
Witness Statement			
16. Describe what you saw, heard, or know about this injury:			
Name of witness:	Email address:		
Mailing Address:	City:	State:	Zip:
Additional Information			
17. Name of Work Trip Leader:			
18. Was care or treatment administered on site? By whom?			
19. Was the injured person(s) taken to a medical facility? If so, how and where?			
20. Based on what is known at the time of this report, does the injured volunteer intend to pursue a worker's compensation claim? Mark one: YES NO UNKNOWN			
21. Lessons learned about hazard(s), recommended PPE, or accident response/injury:			
Please: Convey information on this form to land manager contact and send a photo/scan of this form to volunteer@appalachiantrail.org.			

A.T. Volunteer Injury or Near Miss Explainer

Where did the accident take place? (This answers...Who is the land manager to contact?)

Were you on USFS land?

- Yes:** the land manager to contact is the local USFS district.
- No:** you were working under an NPS Volunteer in Parks agreement, either on NPS, state, or other lands.
 - If the accident was in an NPS unit the Trail goes through (like the Smokies or Shenandoah), contact that unit.
 - In all other locations, report to NPS-APPA as the land manager.

Consult with your A.T. Club's Trail Supervisor or ATC Regional Manager to fill in the contact section below, and *always* be sure that section is complete and current before going out on the Trail.

Land Manager Contact: Fill In For Your Quick Reference:

USFS Ranger District Office Contact*:

*Call and send Injury/Near Miss Report Form.

NPS Park Unit Emergency Contact:

NPS-APPA Chief Ranger: 540-784-0301 / After-hours NPS dispatch line: 1-866-677-6677

Why do I need to fill out the A.T. Volunteer Injury/Near Miss form and call the land manager immediately and within 24-hours?

Contacting the land manager as soon as possible and within 24 hours ensures that A.T. volunteers receive good support from partners within the A.T. network and ensures that reporting deadlines are met. Completing the form as soon as possible helps for the details to be fresh in your mind. The responses on the form are also helpful for the safety reporting requirements (CA-1 form through SMIS or eSafety) that you or federal agency partners will undertake about the incident. By submitting information through your land manager, you ensure that we can learn from the experience, help us track statistics on types of accidents, and support swift action with the Office of Workers' Compensation Program (OWCP), in the event the volunteer wants to file a worker's compensation claim. To facilitate a worker's compensation claim, ask the land manager contact to also send a CA-16 form to the medical facility.

Know that calling the land manager won't trigger recrimination. Consider this open communication about volunteers working on public lands and a best-practice in safety management.

Will requesting the contact send a CA-16 form to the medical facility mean that my claim will be approved?

Not necessarily. The forms are requests that will be reviewed. Examples of claims that are likely to be rejected are things like treatment for Lyme Disease or care related to a pre-existing condition.

If I'm planning to use my own insurance, do I still have to call?

Yes. Any injury to a volunteer should be reported. Close calls and near misses should be reported and entered into SMIS/eSafety. This helps the A.T. network improve hazard awareness and safety training. Also, you might change your mind about not filing a worker's compensation claim. Just in case, it's best

practice to have the CA-1 entered in the federal reporting system as soon as possible.

I didn't seek immediate medical attention but chose to do so later. Now what?

If you contacted your land manager at the time of the injury and completed the CA-1, follow-up with them to update them on any medical attention and outcomes related to your case.

Glossary of Terms

Injury: An effect on your health beyond the scope of normal wear and tear from physical labor with implications such as infection, illness, or the need for medical treatment.

Near Miss/Close Call: An unplanned event that did not result in injury or damage but had the potential to do so. Important near misses to report would be shortcuts, processes ignored, or process errors that without luck or circumstance could have led to serious harm.

Safety Management Information System (SMIS): Utilized by NPS to record injuries and close calls, track statistics on safety, and serve as a basis for lessons learned. Entry of an incident into SMIS is the first step the federal land manager takes to support a worker's compensation claim.

eSafety: Utilized by the USDA Forest Service, fulfills the same purpose as SMIS, above.

CA-1: A form completed and submitted to the federal agency (or through a portal-system) that records information about the accident and people involved. Volunteers should affirm that their CA-1 has been officially submitted through the land manager. The A.T. Volunteer Injury/Near Miss form will prepare volunteers to ensure they have all the information necessary for this form.

CA-16: The form provides government authorization for medical treatment at a medical facility for worker's compensation claims. This form is unavailable to A.T. volunteers. It is provided by the land manager contact to the medical facility providing treatment. Getting this form to the hospital while the patient is still there is ideal, which is why swift notification to the land manager is important. However, it does not need to be at the facility before the volunteer receives care.

E-COMP: An online system of the Office of Worker's Compensation (OWCP).

Worker: an A.T. volunteer serving under a Volunteer Service Agreement with supervision from that organization is considered a federal employee for the purposes of medical compensation for work-related injuries or illnesses (worker's compensation), or for tort claims arising out of their activities as volunteers.

All A.T. volunteers need to be officially signed on through a Volunteer Service Agreement (VSA) with the land management agency. Volunteers or the host organization will need to be able to demonstrate that the person is working under a VSA and provide that upon request.



Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)		1a. Email address	2. Social Security Number	
3. Date of birth	Mo. Day Yr.	4. Gender	5. Home telephone	6. Grade as of date of injury
Level Step				
7. Employee's home mailing address (include street address, city, state, and ZIP code)				
City		State	ZIP Code	
8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other				

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's occupation
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13. Cause of injury (Describe what happened and why)

14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg)	a. Occupation code
	b. Type code c. Source code
	OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days.
If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Worker's Compensation Program (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete this receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness	Date signed	
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Address	City	State	ZIP Code
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If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP.

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include street address, city, state, and ZIP code)		OWCP Agency Code OSHA Site Code	
City _____		State _____ ZIP Code _____	
18. Employee's duty station (include street address, city, state and ZIP code)		City _____ State _____ ZIP Code _____	
19. Employee's retirement coverage <input type="checkbox"/> CSRS <input type="checkbox"/> FERS <input type="checkbox"/> Other, (identify) _____			
20. Regular work hours	From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	21. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
22. Date of Injury Mo. Day Yr.	23. Date notice received Mo. Day Yr.		24. Date stopped work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
25. Date pay stopped Mo. Day Yr.	26. Date 45 day period began Mo. Day Yr.		27. Date returned to work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
28. Was employee injured in performance of duty? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain) _____			
29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? <input type="checkbox"/> Yes (If "Yes," explain) <input type="checkbox"/> No			
30. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to Item 32.)	31. Name and address of third party (include street address, city, state, and ZIP code) City _____ State _____ ZIP Code _____		
32. Name and address of physician first providing medical care (include street address, city, state, ZIP code) City _____ State _____ ZIP Code _____		33. First date medical care received Mo. Day Yr.	34. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No
35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain)			
36. If the employing agency contests continuation of pay, state the reason in detail.		37. Pay rate when employee stopped work Per _____	
Signature of Supervisor and Filing Instructions			
38. A supervisor who knowingly certifies to any false statement, misrepresentation concealment of fact, etc. in respect of this claim may also be subject to appropriate felony criminal prosecution.			
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:			
Name of supervisor (Type or print)			
Signature of supervisor		Date	
Supervisor's Title		Office phone	
39. Filing instructions	<input type="checkbox"/> No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D) <input type="checkbox"/> No lost time, medical expense incurred or expected: forward this form to OWCP <input type="checkbox"/> Lost time covered by leave, LWOP, or COP: forward this form to OWCP <input type="checkbox"/> First Aid Injury		

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (or person acting on the employees' behalf)

1a) Email address

Injured workers should provide an email address when completing this form. Pursuant to policy established by the Department of Labor, Office of Workers' Compensation Programs (OWCP), Division of Federal Employees' Compensation, email communication on case specific inquiries is not allowed due to security concerns. However, obtaining claimant email addresses at the point of filing will allow OWCP to share general, non-case specific information with injured workers earlier in the claims submission process. As a longstanding policy and in an effort to protect the identities and personal information of claimants under the Federal Employees' Compensation Act, and to allow better tracking of incoming communications, we do not use two-way email as a primary method of interaction with claimants and their representatives.)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: If you fell, how far did you fall and in what position did you land?)

Supervisor

As the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing Items 17 through 39, the supervisor is responsible for obtaining the witness statement in Item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency contests COP, the employee should be notified and the reason for contestation explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

14) Nature of injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

33) First date medical care received

The date of the first visit to the physician listed in Item 31.

36) If the employing agency contests continuation of pay, state the reason in detail.

COP may be contested (disputed) for any reason; however, the employing agency may refuse to pay COP only if the contestation is based upon one of the nine reasons given below:

- a) The disability was not caused by a traumatic injury.
- b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;
- c) The employee is not a citizen or a resident of the United States or Canada;
- d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;
- e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;
- f) The injury was not reported on Form CA-1 within 30 days following the injury;
- g) Work stoppage first occurred 45 days or more following the injury;
- h) The employee initially reported the injury after his or her employment was terminated; or
- i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Instructions for Completing Form CA-1 Continued

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines."

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continues the employee's pay, the pay must not be interrupted unless one of the provisions outlined in 20 CFR 10.222 apply.)
- (2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.
- (3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where directed by OWCP.

(5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by (Name of injured employee)

Which occurred on (Mo. Day, Yr.)

At (Location)

Signature of Official Superior

Title

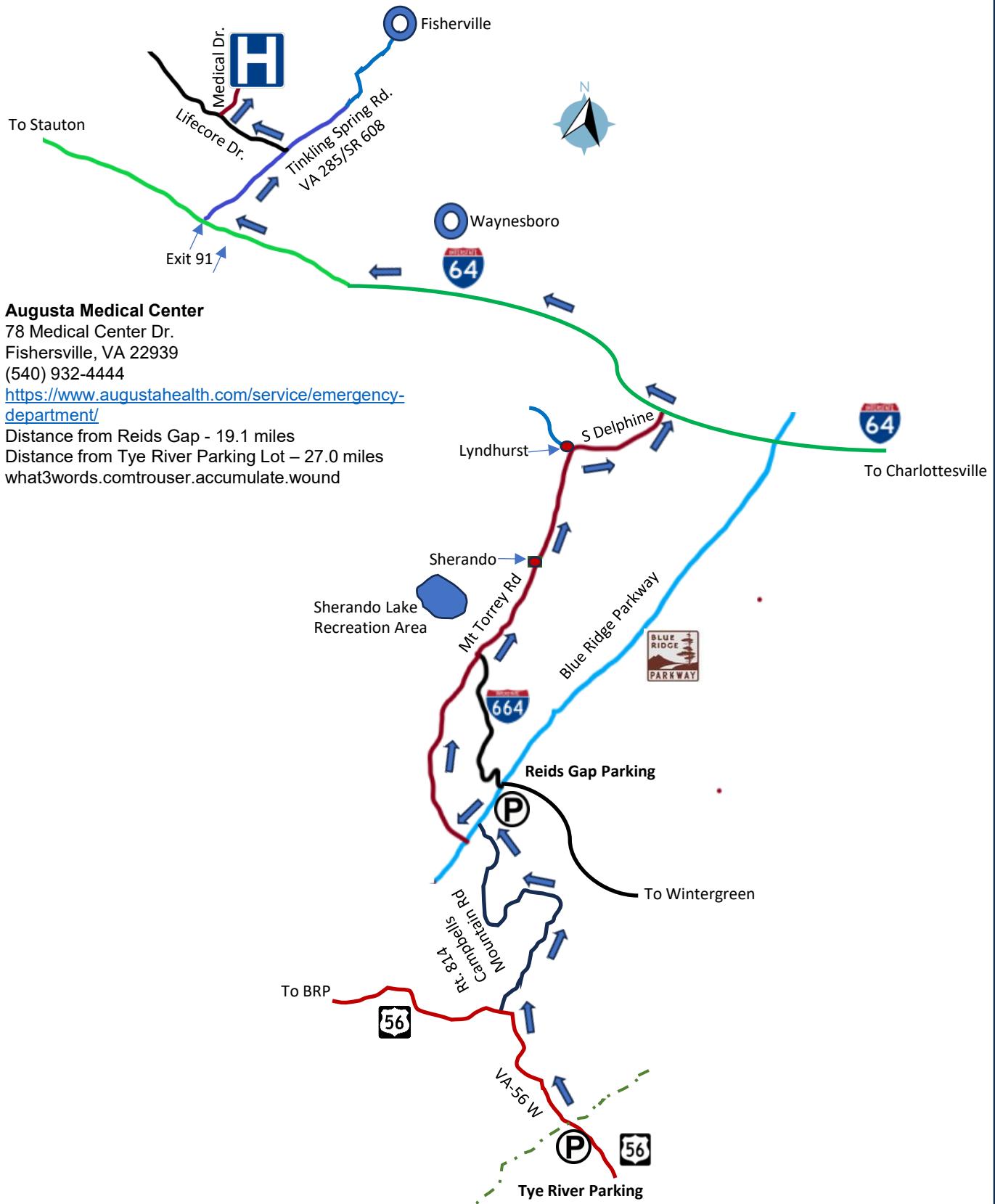
Date (Mo. Day, Yr.)

Reids Gap to Augusta Medical Center Emergency Department



Reids Gap to Augusta Medical Center Emergency Department	Mileage
From Reids Gap Parking Lot - follow State Rte. 664 to Mt Torrey Rd	2.0 miles
Right on Mt Torrey Road (Rt 664) to S Delphine Rd (Rt 624)	9.3 miles
Turn left off S Delphine Rd to merge onto I-64 W toward Staunton	1.4 miles
Continue on I-64 W toward Staunton	5.1 miles
Take exit 91 for VA-285/State Route 608 toward Fishersville	0.8 miles
Turn left onto Lifecore Dr	0.5 miles
Turn right onto Medical Center Dr	0.1 miles
Destination will be on the right	
Total Distance:	19.2 miles

Tye River Parking Lot to Augusta Medical Center Emergency Department



Tye River to Augusta Medical Center Emergency Department	Mileage
From Tye River Parking Lot – turn left onto Rte 56W to Rte 814	1.3 miles
Right on Rte 814 Campbells Mountain Road to Blue Ridge Parkway	4.5 miles
Left on Blue Ridge Parkway then turn Right onto Rte. 814 after 0.1 mile	0.1 mile
Continue on Rte 814 and then continue straight onto Mt Torry Rd	3.9 miles
Continue on Mt Torry Road (Rt 664) to S Delphine Rd (Rt 624)	9.3 miles
Turn left off S Delphine Rd to merge onto I-64 W toward Staunton	1.4 miles
Continue on I-64 W toward Staunton	5.1 miles
Take exit 91 for VA-285/State Route 608 toward Fisherville	0.8 miles
Turn left left onto Lifecore Dr	0.5 miles
Turn right onto Medical Center Dr	0.1 miles
Destination will be on the right	
Total Distance:	27.0 miles

Urgent Care is for Injuries that are not Emergencies

Waynesboro Urgent Care

201 Lew Dewitt Blvd, Suite A Waynesboro, VA 22980

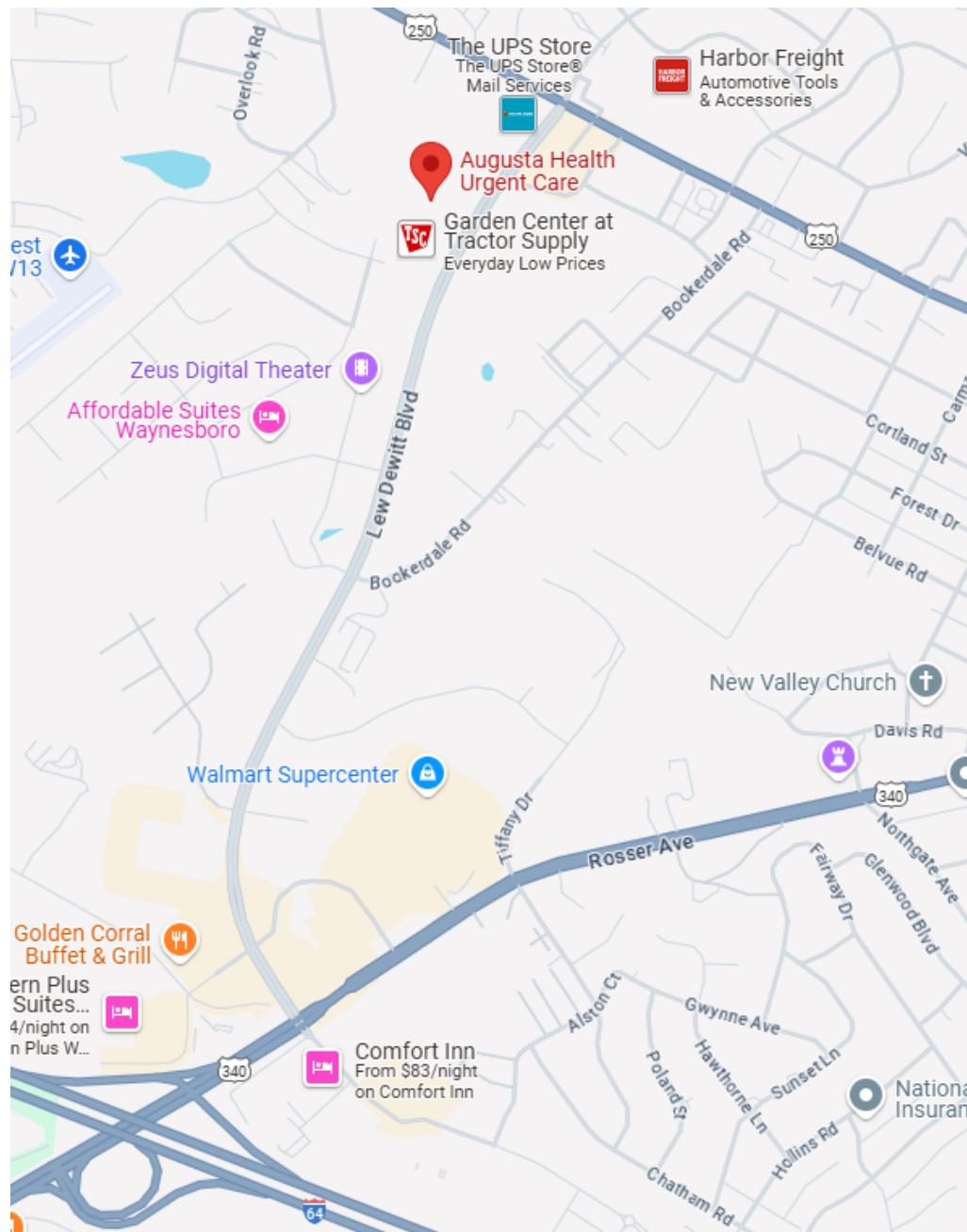
540-245-7940

Hours

Sunday - Saturday 8:00 am-7:00 pm

Imaging & Laboratory

Mon-Fri: 7:00 am-5:00 pm



Urgent Care is for Injuries that are not Emergencies

Stuarts Draft Urgent Care

2570 Stuarts Draft Hwy, Suite 100 Stuarts Draft, VA 24477

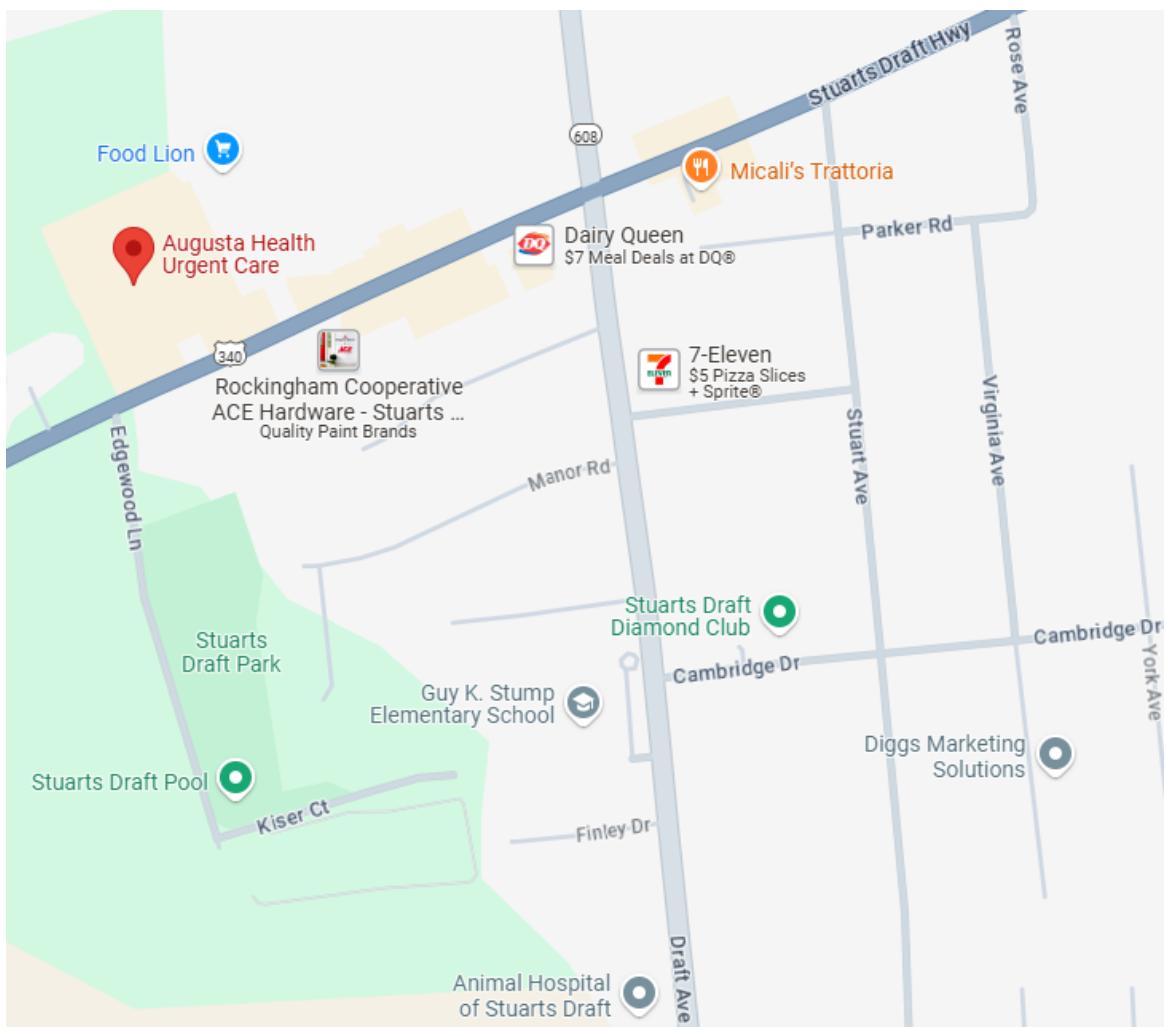
540-245-7880

Hours

Sunday - Saturday 8:00 am-7:00 pm

Outpatient Lab

Monday-Friday, 7:00am-5:00pm



Emergency Departments

Augusta Medical Center

78 Medical Center Dr.
Fishersville, VA 22939
(540) 932-4444

<https://www.augustahealth.com/service/emergency-department/>

Distance from Reids Gap - 19.1 miles

Distance from Tye River Parking Lot – 32.1 mile
what3words.comtrouser.accumulate.wound

University Hospital

1215 Lee St.
Charlottesville, VA 22908
(434) 924-2231
(434) 924-9295 Fax

<https://uvahealth.com/locations/Emergency-Department-5597289>

Distance from Reids Gap - 38 miles

Distance from Tye River Parking Lot – 48 miles

Urgent Care

MedExpress Urgent Care

medexpress.com

Phone number
(434) 978-3998

1149 Seminole Trl
Charlottesville, VA 22901

<https://www.medexpressurgentcare.com/location/va/charlottesville/ssv>

Augusta Health - Stuarts Draft Urgent Care

2570 Stuarts Draft Hwy
Suite 100 Stuarts Draft, VA 24477
540-245-7880

Hours Sun-Sat: 8:00 am-7:00 pm

<https://www.augustahealth.com/service/urgentcare/urgent-care-check-in/>

Augusta Health - Waynesboro Urgent Care

201 Lew Dewitt Blvd, Suite A
Waynesboro, VA 22980
540-245-7940

Hours Sun-Sat: 8:00 am-7:00 pm

<https://www.augustahealth.com/service/urgentcare/urgent-care-check-in/>

Sheriff Offices

Nelson County Sheriff

84 Court House Square
P.O. Box 36
Lovingston, VA 22949
Mark Embrey Sheriff
Email: sheriff@nelsoncounty.org
Phone: 434-263-7050 or 800-750-5757
Fax: 434-263-7056

Augusta County Sheriff's Office

127 Lee Hwy, P.O. Box 860
Verona, VA 24482
Donald L. Smith Sheriff
Email: acso@co.augusta.va.us
Phone: [540.245.5333](tel:540.245.5333)
Fax: 540.245.5330

A.T. Volunteer Activity -- Emergency Response Plan

Section 1: Project Information	
Project Name:	Date(s) for the project:
Club:	Club Section(s):
Land Manager Partner Agency:	ATC Region:
Brief Project Description (Worksite plans, Lat/Long, access plans; Campsite location, driving directions, lat/long)	

Section 2: Resources	
First Aid Training of Leaders and Participants:	
First Aid Kit(s) location:	FA Kit Checked/Refreshed Date:
VIP/VIF Packet: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Satellite Communicator/SPOT/Inreach Device: <input type="checkbox"/> Yes <input type="checkbox"/> No Notifies:	
Batteries charged/replaced (date):	
Cell phone reliability information at parking / worksite / campsite:	
Trail Map: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 3: Emergency Resources	
Hospital/Clinic Contact (attach map to the hospital from worksite and campsite locations)	
Hospital/Clinic Name:	Phone Number:
Location:	Distance in min/miles:
Road crossings to N and S of project:	
Written directions to trailhead and project site (in case 911 Dispatch needs directions to route EMS):	

Section 4: Action	
1) If injury is serious/critical, evacuation and treatment should be priority. According to your communication capabilities, either find service and call 911 or use the SOS button on your satellite communicator. Once 911 and EMS is engaged, contact land manager for coordination and support.	
2) What is the plan for supervising the remaining program participants while treatment/assistance is being rendered? Note that plans should not leave remaining participants without a vehicle.	
3) Additional plans for injuries to crew leaders: Discuss contingency plans and options during tailgate safety session in case crew leader(s) are injured. Specific information that should be shared and discussed during tailgate safety session should include: sharing where keys, first aid kits, SPOT/satellite communicator, ERP/project info sheets are located in backpacks; other crew volunteers first aid and CPR certification levels, possible 'back-up' crew leader in case of emergency, etc. List contingency plans for participant/member and crew leader evacuation. Include agency support available and existing contingency plans.	

Section 5: Documentation	
It is important to report near misses as well as volunteer injuries are properly documented as close to the time of the emergency as possible. Utilize the instructions in your VIP/VIF packet.	



Incidents: What to do when...

A.T. Partners and maintainers may encounter any number of issues. This quick reference tool helps direct appropriate action.

Corridor Encroachment Identified

- When corridor monitoring does uncover encroachments, the Trail club volunteers, ATC, and partner agencies work cooperatively to address the problems. The strategies used to address a problem will depend on its nature and severity.
- Complete [Encroachment Report Form](#) and share with the regional Stewardship Manager
 - [Encroachment flow chart](#) will determine how the issue is managed and by whom.
- If encroachment is currently occurring, contact the appropriate land manager ASAP.

Volunteer Injury or Close Call

- If an injury occurs, a volunteer should follow [this flow chart](#) or steps below:
 1. Immediate care and First Aid, and/or treatment at a medical facility.
 2. Complete the A.T. Volunteer Injury/Near Miss Form in advance of calling the land manager.
 3. Call the land manager no more than 24 hours after event to report and extend volunteer protections. Ask the land manager to submit a CA-16 to the medical facility if a workers compensation claim will be filed.
 4. Send the [A.T. Volunteer Injury/Near Miss Form](#) to ATC (volunteer@appalachiantrail.org), your ATC regional office, and land manager (if requested).
 5. Follow-up

Emergency Incidents

- When medical attention or an immediate law-enforcement response is necessary, call 911.
- Once 911 is activated, as time allows, contact the National Park Service 24-Hour Dispatch/Communications Center Non-Emergency Line to inform them of the situation: 1.866.677.6677
- Complete the Incident Form: <https://appalachiantrail.org/at-incident-form/>
- If you're an A.T. Club in contact with area Search and Rescue groups, make them aware to use the non-emergency line to share information after their efforts are complete. This helps land managers, ATC, and states know the impact and value of local and regional emergency responders specific to the A.T.

Non-Emergency Incidents (public health or safety related to the Trail, facilities, or natural resources)

- If you are not in immediate danger but observe ongoing or recent vandalism or resource damage on the A.T., or just feel like something should be reported, contact the National Park Service 24-Hour Dispatch/Communications Center Non-Emergency Line to inform them of the situation: 1.866.677.6677
- Complete the Incident Form: <https://appalachiantrail.org/at-incident-form/>

A.T. Volunteer Grievance related to Conduct

- Most instances of actions in conflict related to volunteer safety and aspects of professional behavior are corrected within the organization hosting the volunteer. However, when that is not possible, [filing a grievance](#) may be necessary to spark corrective action and initiate opportunities for healing and restoration of trust.
- Reference Standards of Care for A.T. Volunteers for appropriate behavior and organizational code of conduct for related processes.

Bear Incident Form

- Did you have one of the following encounters on the Appalachian Trail where a bear:
 - Entered a campsite or shelter area.
 - Attempted to (or did) steal food.
 - Was aggressive toward you, another hiker, or a pet.
 - Damaged property.
 - Was following you while you were hiking.
 - Was acting strangely.
- Fill out a Bear Incident Form: <https://www.surveymonkey.com/r/CCYZGC2>