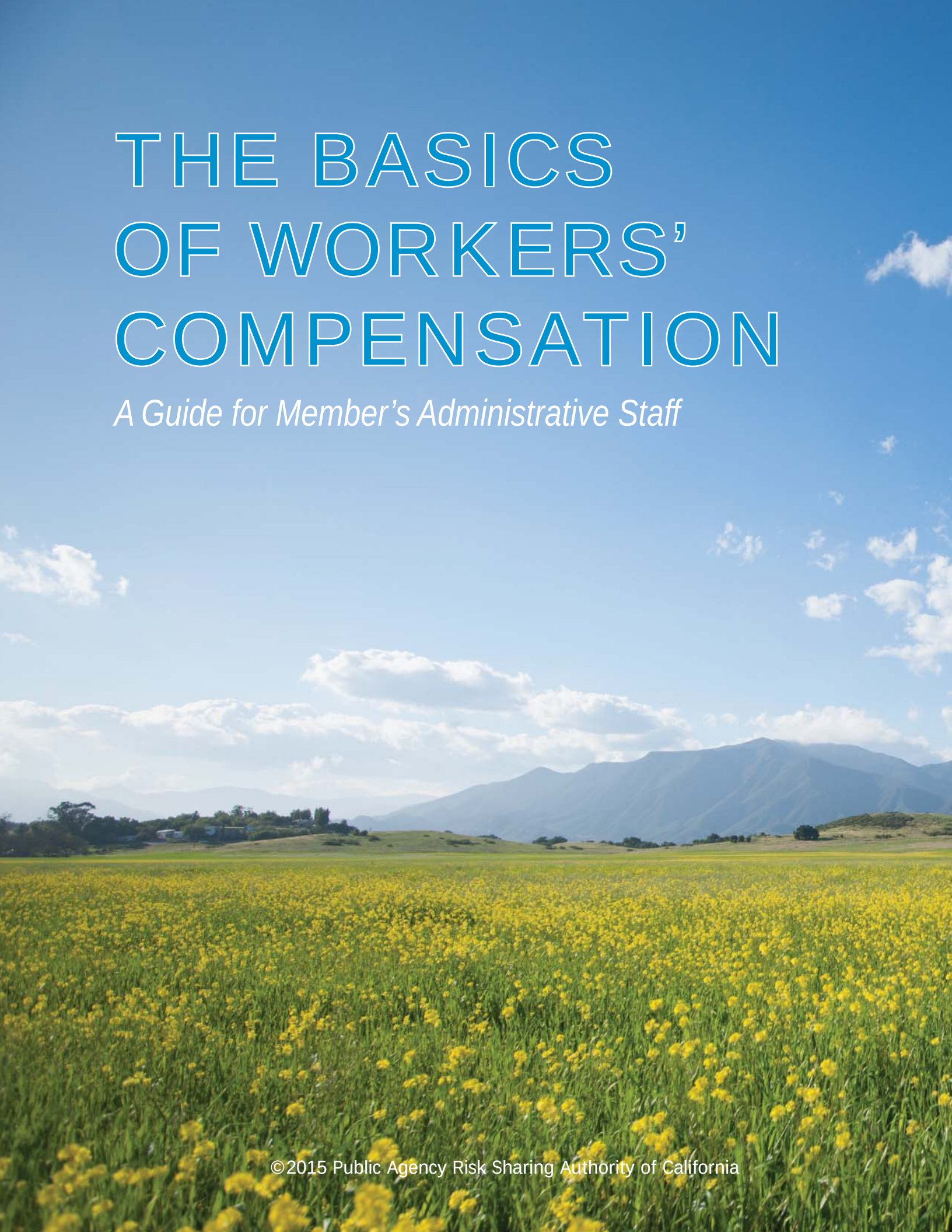

THE BASICS OF WORKERS' COMPENSATION

A Guide for Member's Administrative Staff

Established 1986

PARSAC
PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA

The *Basics of Workers' Compensation Guide* is intended to provide basic information about the workers' compensation benefit delivery system for your agency. It is intended to communicate information in plain English and is not a replacement for professional administrative services or legal advice. Please customize the Guide to meet your organization's specific needs and procedures, and use it to educate supervisors and other staff with responsibility for the workers' compensation process. Included in the Exhibits are brochures (Facts for Injured Workers and Frequently Asked Questions) which are suitable for distribution to all staff during orientation and should also be provided at the time of injury.

IMPORTANT: The information provided in this Guide references action to be taken on injuries which occur on or after 1/1/2013; injuries/claims prior to that date may have different benefit levels and regulatory requirements. PARSAC and its service providers are available to address any and all questions.

Workers' compensation regulations are frequently updated and we will strive to incorporate these changes in a timely manner. You can find the most current Guide and exhibits on the PARSAC website: http://www.parsac.org/services/bestpractices/.

PARSAC would like to thank and acknowledge Gerald Lenahan of Lenahan, Lee Slater & Pearse and Carolyn Richard, Law Offices of Stacey Takenaga, as well as Julie Simpson and Elizabeth George of Athens Administrators for their review, guidance and contributions to this Guide.

THE BASICS OF WORKER'S COMPENSATION

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I. INTRODUCTION

(Your Agency) values and takes seriously its commitment to provide a safe place to work. The best accident is the one that does not happen. Supervisors are in the best position to influence that outcome by encouraging safe work practices, analyzing complex tasks before they are performed, and implementing corrective actions.

If It's Predictable, It's Preventable

When accidents and injuries are prevented, employees' quality of life improves and taxpayer funds not spent on claims become available for agency programs, services, employee salaries and benefits. We strive for a cooperative workplace environment where communication and education provide employees with the tools they need to stay safe. This approach begins with each new employee's orientation and is reinforced through safety meetings and training.

However, in the event of a work related injury or illness, it's our goal to provide prompt access to high quality medical care, all due benefits, and return employees to work as soon as they are able. (Your Agency) strives to maintain open communication with injured employees about their rights and benefits so that they can make informed decisions about their care.

II. WORKERS' COMPENSATION COVERAGE

(Your Agency) is self-insured and is a member of PARSAC, the Public Agency Risk Sharing Authority of California for workers' compensation coverage. PARSAC is a joint powers authority providing group self-insurance for public agencies. It is not an insurance company and does not have the profit motive of an insurer. PARSAC's mission is to provide benefits. PARSAC also provides a number of resources, from claims administration and nurse advocacy to specialty care and pays workers' compensation benefits. PARSAC also works with the Agency to prevent accidents that can adversely impact an employee's health and well-being.

(Your Agency)'s workers' compensation claims are managed by (Name of TPA), which is a third party claims administrator (TPA). The contact information for the TPA is:

(Claims Adjuster)
(Company Name)
(Mailing address)
(Phone / email / website)

A. A No Fault System

An injury or illness that arises out of and occurs in the course and scope (AOE/COE) of employment is covered under a system called Workers' Compensation which is regulated by the State of California, Department of Industrial Relations (DIR), Division of Workers' Compensation (DWC). The system also covers registered volunteers if (before the injury occurs) the Council/Board has adopted a resolution to do so. Workers' Compensation is a "no fault" benefit delivery system which means coverage is automatic, immediate, and benefits cannot be denied due to employee negligence.

1. Types of Injuries

   - *Specific Injury*: a one-time occurrence, such as a laceration or fracture;
   - *Cumulative Trauma Injury*: occurs over time from repeated, long-term exposure, such as hearing loss. Cumulative trauma can result in injury or occupational disease.
   - *Presumptive Injury or Illness*: arises from the unique exposures of sworn public safety personnel is rebuttably presumed to be work related. Some examples are heart disease, certain cancers, blood borne diseases, lung conditions, and back or hernia injuries. A presumptive injury is not based upon scientific fact or medicine. It is a benefit conferred by statute.

2. Injury Categories

   - *First Aid*: an employee has a minor injury and needs either on-site care or an office visit (Refer to Attachment A, Cal/OSHA "Recordable" Guidelines & Definition of First Aid).
   - *Medical Only*: the employee is off work less than three days and has medical appointments only.
   - *Indemnity (lost time)*: an employee is off work for three days or more, is hospitalized, or has more than two doctor visits. The injured employee must provide a written doctor's order that instructs them to be off work.

3. Types of Workers' Compensation Benefits

   - *Medical Care*: All reasonable and necessary medical care to cure or relieve the effects of injury or illness. There are no out-of-pocket expenses, deductibles, co-payments, etc. Medical treatment may be subject to utilization review to determine appropriateness of care for the type of injury. Injured workers may seek care from their pre-designated doctor, an occupational facility familiar with treating work-related injuries, or the Agency's network of occupational specialist care providers (Attachment B).

     a. *Option to Pre-Designate Physician.* It is recommended that this option be included in the new employee orientation along with other Agency benefits

and programs. Employees may select their own doctor to treat them for a work-related injury, if the following **three** conditions are met (see Attachment L, 8 CCR §9780):

i. The request is made in writing BEFORE an injury occurs (Attachment C);

ii. The employee has regular health care coverage in place when injured; and

iii. The physician agrees to be pre-designated before the injury and must have treated the employee previously.

The Employer retains medical control for the first thirty (30) days, unless the employee is being treated by their pre-designated doctor. After thirty (30) days, the employee may request, in writing, a change of treating doctor.

All medical information should be stored separately from personnel files and kept secured.

- *Wage Replacement*: Tax free payments to help replace the employee's lost wages if they become temporarily or permanently disabled.

a. *Temporary Disability (TD).* There is a three (3) day waiting period before TD benefits are issued, which is waived if admitted to the hospital, or if the time off extends to 14 days.

TD benefits are based on two-thirds of the average weekly wage, up to a statutory maximum of $1103.29 per week in 2015, $1128.43 for 2016, and $1,172.57 for 2017. TD checks are issued by the claims administrator every fourteen (14) days.

TD payments are "capped" at 104 weeks and do not extend beyond five (5) years from date of injury not the date employee goes off work.

i. Wage Statements: In order to properly calculate benefits, the claims administrator requires total wages for the prior 52 weeks. If a wage statement is not provided, and the employee is a "below maximum wage earner," then the maximum TD rate must be paid. Be sure to notify the claims administrator if the employee has a second job/other income as these wages must be included in the benefit calculation.

Some agencies offer Salary Continuation, which allows injured workers to augment their disability benefits with available sick or vacation time (refer to Attachment L, Online Resources for sample form). This benefit is negotiated and not subject to additional reimbursement under the labor code.

b. *"4850" Benefits (Labor Code §4850(a))*. Public safety personnel receive "4850" benefits, which entitles them to a leave of absence without loss of salary for up to one year in lieu of TD (see above). If the recovery takes longer than a year, then TD benefits are provided for an additional year* or until the injured worker reaches permanent and stationary (P&S) status.

**Under certain circumstances, temporary disability benefits can total 240 weeks.*

PARSAC only pays up to the temporary disability amount, not 4850 (refer to the Memorandum of Coverage, Attachment L). If the full salary is less than maximum temporary disability, PARSAC will reimburse the full salary.

Depending on the Agency's preference, the claims administrator can reimburse the TD amount paid by the Agency or issue payment directly to the employee. The Agency is then provided a voucher for their records to document the difference between the TD and 4850 amounts.

c. *Permanent Disability (Labor Code §4660)*. Employees may receive an award of permanent disability benefits if the injury/illness leaves them permanently limited in their ability to work. Rates are based on average weekly earnings in conjunction with level of disability as determined by the doctor. Rates range from $160 - $290 per week (as of 1/2014) and are intended to compensate the employee for the loss of specific function(s). PD is based on a rating schedule from 0-100%, established by the State, and paid weekly after TD ends or the condition is deemed "permanent and stationary" (P&S).

A Supplemental Job Displacement Voucher of up to $6,000 (for injuries occurring on or after January 1, 2013) is available if the injured worker is unable to return to his/her pre-injury employment.

- *Death Benefits.* Burial expense of $10,000 is provided, as well as income replacement benefits for full or partial dependents of: $250,000 for 1 dependent; $290,000 for 2; $320,000 for 3, or more.

Refer to Online Resources (Attachment L) for links to obtain current information on the above Workers' Compensation benefits and rates. In addition, a brochure published by the DWC "Facts About Workers' Compensation" can be provided to employees (Refer to Attachment L, Online Resources).

B. Responding to an Injury

Prompt reporting of incidents and accidents provides an opportunity to assist injured employees with treatment, rehabilitation, benefits, and early return to work, whenever possible. Reporting also provides an opportunity to determine the cause of accidents and develop solutions to prevent recurrence.

State required postings (see Attachment L, Online Resources) should be available where employees are most likely to see them. In addition to the OSHA required poster (Attachment D), the notice area should include: instructions on reporting injuries; where to seek medical assistance; and contact information for the claims administrator.

Upon receiving notice that an employee has been injured (or ill), instruct the injured worker seek immediate medical treatment as follows:

1. Life Threatening Injuries

   If the injury is life threatening, take appropriate steps to prevent further injury, call 9-1-1, and/or secure transport to the emergency room (refer to Attachment C).

   Contact the local Cal/OSHA office within 8 hours if the following occurs: work-related or suspected work-related fatalities, catastrophes, and serious injuries or illnesses.

   A serious injury or illness is one that requires employee hospitalization for more than 24 hours for other than medical observation, or in which a part of the body is lost or permanent disfigurement occurs. Failure to timely report may result in a fine of $5,000. Refer to the Online Resources to identify your local office (Attachment L).

   Ensure that the employee receives a DWC-1, Workers' Compensation Claim form, within 24 hours of the injury (see Attachment E). Contact family if appropriate, and have the supervisor (or HR) check on the employee. Call the claims administrator/PARSAC to report the injury as soon as possible. A nurse will be assigned to follow up and specialty care provided.

2. Non-Emergencies

   In non-emergency situations, hand the employee the DWC-1 and Express Scripts Temporary Pharmacy ID Card (Attachment F), which allows the employee to receive their first prescription without any out-of-pocket expense. The employee should also carry with them an up to date job description, so that the doctor will understand the physical demands of the job and make appropriate treatment recommendations or address restrictions. Once the claim is accepted,

the claims administrator will issue a permanent pharmacy benefit card for future prescriptions.

The supervisor or co-worker should transport the injured worker to the occupational medical facility or pre-designated medical provider. This sends the message that the Agency cares for its employees, and also provides the Agency with immediate information on the employee's condition and care needs.

3. First Aid Only

   For First Aid injuries, medical services can be paid by the claims administrator or directly by the Agency. The injury should be logged on the Department Incident Log (Attachment G) but does not require a DWC-1 claim (Attachment E) form and does not need to be recorded for OSHA purposes (refer to Attachment A). **If you are unsure that an injury would be considered "first aid," please contact your claims administrator/PARSAC for assistance.**

For all injuries complete the 5020 form, Employer's Report of Occupational Injury or Illness, as soon as possible **but no later than five days** after **knowledge** of an injury/illness. Inputting the correct information on the form will expedite benefits and allow the claims administrator and PARSAC to identify accident trends and direct services. Most claims administrators have an online 5020 form (see Attachment H, LWP online 5020 Instructions) or the standard form may be used (see Attachment I, DIR Form 5020) and submitted to the claims examiner.

Contact the claims administrator/PARSAC for assistance or with any questions about your employee's care. If you suspect the injury may not have occurred as reported, or have information that would assist the medical provider in delivering appropriate care, contact the claims administrator and PARSAC immediately.

C. Roles and Responsibilities

Employee: Employees are responsible to work safely and report safety concerns to their supervisor. The Employee is also responsible for notifying his/her supervisor of a work related injury or illness; filling in the "Employee section" of the DWC-1 (Attachment E); and returning it signed and dated to their Supervisor (or HR).

- Not all employees will return the claim form or seek medical attention. Delays in reporting may delay benefits; it's important to remind employees to report injuries promptly to protect their benefits. The Supervisor may need to seek assistance from Admin/HR, the claims administrator, or PARSAC.

Post-injury, it's the employee's responsibility to follow doctor's orders, take medication as prescribed, attend physical therapy appointments, and if returned to work in a modified capacity, work within the doctor's restrictions

Supervisor's Role: is to provide a safe work environment for all employees. Follow the Agency's Injury and Illness Protection program (IIPP), hold regular safety meetings, perform periodic safety inspections, and provide training specific to the hazards likely encountered on the job.

The supervisor is often the first person to become aware of an employee's injury. The supervisor's notice comes in many forms: a witnessed accident; reports from coworkers; observation of an employee limping; or, even overhearing a conversation. Once on notice, the supervisor should take prompt action to investigate the circumstances of the alleged incident or accident, speak with the injured worker, and ensure that a DWC-1 (Attachment E) and assistance with medical treatment are provided. On occasion, it becomes the supervisor's responsibility to ensure the employee knows their workers' compensation rights and benefits.

It's also important for the Supervisor to stay in touch with the injured employee, check on their recovery progress, express concern, and smooth out any obstacles to recovery. In many cases, a simple get well card can go a long way in showing the employee that their recovery is important to the Agency. The claims administrator and PARSAC can provide assistance in this area.

Remember:

- ✓ **DO NOT discuss or share confidential claims information with other employees;**
- ✓ **Complete reports and investigation timely; and**
- ✓ **Communicate all information to Admin/HR as soon as possible.**
- ✓ **Immediately mail, fax, or email the completed DWC-1 to the claims administrator. The employer has only 90 days to conduct an investigation to accept or deny a claim. Failure to provide a DWC-1 may forfeit your right to contest or deny a claim that did not occur from the course and scope of employment.**
- ✓ **Visit your industrial medical provider annually to update your "client profile" and maintain a relationship with the medical providers and office staff. They are key in helping to appropriately treat and return your employee to work. It's also important to establish a relationship with other providers, specialists and the local hospital ER staff who will be in a position to expedite care for your employees.**

III. INVESTIGATING ACCIDENTS

A thorough supervisory accident investigation may be instrumental in identifying whether an unsafe work practice or an unsafe condition was the proximate cause of the accident (forms provided under Attachment J). Absent a good investigation and corrective action, accidents will reoccur. Remember:

If It's Predictable, It's Preventable!

If equipment is found to be a contributing factor, retain the equipment securely, and contact PARSAC. There may be an opportunity to recover funds for both the injured worker and the Agency. If it's determined that a work practice contributed to the accident, it may be an opportunity for training to prevent recurrence.

While the investigation will find that a majority of injuries are legitimate and unfortunate, there are certain "red flags" which require further consultation with the claims administrator and PARSAC, which are:

- A brand new employee.
- No witnesses to substantiate the injury, or witness statements are inconsistent with injured worker statement
- Injury claim is inconsistent with the mechanics of the accident.
- Employee has multiple claims.
- Employee is subject to disciplinary action or performance review.
- Monday morning or Friday incidents.
- Injury claims following vacation or holidays.
- Late notice of injury or illness.
- Discrepancy between statements to doctor, coworkers, and/or supervisor.
- Known or rumored financial difficulties.
- Secondary employment.
- Reports from co-workers or anonymous sources questioning the claim.

The investigation may also find other factors directly related to the employee's behavior contributed to or caused the accident. In these cases, there are affirmative defenses available to the Agency, which are when the employee:

- Was under the influence or intoxicated;
- Was the initial physical aggressor in an altercation;
- Was injured during off-duty activities or by activities not arising in the course and scope of employment;
- Was engaged in horseplay;

- Self-inflicted the injury; and/or
- Committed a felony or misdemeanor.

If any of the above red flags are suspected, CALL the claims administrator or PARSAC as soon as possible. Retain all memos, emails, and documents which may be useful. Identify witnesses and provide contact information.

IV. CLAIM HANDLING PROCESS

Under certain circumstances, a claim may be delayed for further investigation by the claims administrator. While under investigation, the employee can continue medical treatment up to $10,000. Once sufficient medical information is received, which may include pre-injury medical records, the claims administrator will determine (within 90 days) to accept or deny the claim. The employee's right to medical treatment during this investigation period does not start until a fully completed DWC-1 is provided to the employer.

- **If accepted**, treatment will continue and the Agency will be asked to provide: a current job description; a current wage statement for temporary disability benefits (if the employee is off work); and a plan for the employee to return to work in a modified capacity until fully recovered.

  PARSAC provides numerous "transitional" tasks for modified duty to fit most restrictions (refer to Attachment L). The goal is to return the injured worker to the workplace as quickly as possible to minimize wage loss and maximize recovery.

- **If denied**, the employee may be able to address the denial as simply as supplying additional information or seeking clarification from the claims administrator. Alternatively, the injured worker has some options:
  a. The employee can continue treatment under the Agency's health care program and use sick leave for time away from work.
  b. The employee may also be eligible for the Agency's short and long term disability programs and/or state or federal disability coverage.
  c. The employee may also request job protection under Federal and State Family Leave laws (CFRA/FMLA), which, if the Agency is subject to those regulations, they may be run concurrently with either temporary disability or another leave program to a maximum of 12 weeks.
  d. The employee may seek assistance from the DIR's Information and Assistance Unit. This Unit can assist the employee in getting a Qualified Medical Examiner evaluation (QME), or an Independent

Medical Review (IMR) for any treatment deemed not medically necessary.

e. The employee may also seek representation from an attorney.

Whether a claim is accepted or denied, it is preferable to discuss the employee's concerns and provide assistance, which may prevent litigation. Litigation can delay treatment and increase costs. The employee will receive copies of all evidence and correspondence related to the claim, unless they are represented by an attorney. Regardless of whether the employee has an attorney, the Agency should keep the lines of communication open.

Once a claim becomes litigated, the claims administrator will only be able to communicate with the employee's attorney. The case will also be assigned to a PARSAC Defense Panel attorney, who will seek additional information about the injured employee including but not limited to: background, prior or secondary employment, and may result in an activities check called sub-rosa investigation. Even after the employee retains counsel, he or she remains subject to the Employer's policies and procedures and must continue to advise the employer of his or her ability to work and cooperate fully with Employer's requests to remain in contact.

A. Return to Work

The purpose of a Return to Work (RTW) program is to formalize a plan for bringing an injured worker with temporary restrictions back into the workplace as quickly as medically appropriate to speed the employee's recovery process. The broad objectives of RTW are to facilitate the physical and psychological recovery process, minimize the chance of re-injury, reduce the cost of overtime or replacing employees, and improve workplace morale.

The most effective way to do that is to start early. A well-defined job description with essential duties and physical/mental requirements is critical so that the employee, doctor, claims administrator, and Agency can work together to plan a series of tasks (transitional duties) that improve the recovery process and likelihood of a return to full duty and add value to the Agency. In some instances a work hardening or functional restoration process may be undertaken to better prepare the injured employee to return to work. On rare occasion, a Functional Capacity Evaluation (FCE) may be used to determine the employee's abilities/restrictions.

An employer is not required to pay TD if an offer of temporary modified or duty or alternative work is made and the employee ignores or refuses the offer. It is the employer's burden to prove work was available, the work was within the employee's restrictions or limitations, and the offer was expressly communicated to the employee.

Throughout the recovery process it's important to continue to meet with the employee, identify any barriers to recovery, ensure the employee is working within restrictions, and plan for a return to full duty.

PARSAC's Return to Work program is available online and includes all necessary forms and has a detailed "bank" of transitional tasks (Refer to the Attachment L).

B. Interactive Process

Where it is unlikely that an employee will recover sufficiently to return to their pre-injury job duties, engaging in an interactive process is in everyone's best interest and required by law. The process should identify the employee's permanent restrictions, need for accommodation, and whether or not the pre-injury job duties could be modified as an accommodation.

Interactive is the key. This process is an exchange of ideas with the intent of providing options for the injured employee within the Agency. There is no requirement to create a job for an injured worker. However, there is an obligation, which may be governed by the Agency's MOUs, to engage the employee in discussion, assess eligibility for any open positions for which the employee may be otherwise qualified, and actively seek options for retaining the employee (Refer to Attachment L for PARSAC's ADA Accommodation Policy & Procedures); a sample script is provided for reference (Attachment K).

It is prudent to seek advice on the process from labor counsel, which is available through the Liebert Cassidy Whitmore Consortium or ERMA consultative services.

If the employee is unable to return to his/her pre-injury job duties, they will be eligible for benefits under the workers' compensation system and may also be eligible for benefits from other sources.

V. RESOLVING A WORKERS' COMPENSATION CLAIM

An injured employee can resolve their claim in many different ways.

The claim can be closed when the employee has reached maximum medical improvement (MMI), is permanent and stationary (P&S), returns to the pre-injury job, all issues have resolved, and all benefits have been paid.

A claim can be resolved by one of three options:

1. *Stipulations*: a legal form in which permanent disability (PD) may or may not be awarded but the doctor orders future medical benefits;

2. *Compromise and Release (C&R)*: a document where the employee agrees to resolve the claim inclusive of future medical care costs for increased compensation; or
3. *Trial*: where a Judge decides and issues a Findings and Award.

One consideration in resolving claims by C&R is to ensure that the employee is not eligible for Social Security Disability or Medicare (regardless of age). If they are, Medicare's interests must be protected and a Medicare Set Aside (MSA) be established to provide funds for future medical care.

While medical costs for an accepted claim are the responsibility of the employer, permanent disability benefits can be apportioned to prior claims or non-industrial conditions, if any.

VI. OTHER LEGAL ISSUES

A. Serious and Willful Misconduct

On rare occasion an injured employee may allege that the Agency's action or inaction on a safety related condition was a violation of labor code defined as "serious and willful" misconduct. In order to prevail, an employee must show:

1. There was a violation of a safety order.
2. The violation of the safety order was the proximate cause of the injury.
3. The employer or the employer's representative (a particular named person) had knowledge of the dangerous condition, or that the condition making the safety order applicable was obvious, created a probability of serious injury, and that the failure of the employer, or a representative designated by Section 4553, to correct the condition constituted a reckless disregard for the probable consequences.

In the case of a Serious and Willful (S&W) misconduct violation the penalty is an increase in benefits of fifty percent (50%). By law in California neither PARSAC nor any insurer can provide coverage for this penalty. The 50% penalty is assessed against all payments for the life of the claim and has no monetary cap or maximum. By way of example if the total payout on the claim was $1,500,000 the S&W penalty would be $750,000.

B. Violation of Labor Code 132A

This is a provision in Labor Code that prohibits discrimination of an employee for filing a workers' compensation claim. The employer may be found guilty of a misdemeanor and the employee's compensation increased by one-half, but in no

event more than ten thousand dollars ($10,000), together with costs and expenses not to exceed two hundred fifty dollars ($250). The employee shall also be entitled to reinstatement and reimbursement for lost wages and work benefits. PARSAC provides defense coverage for this action up to $10,000 but does not cover damages.

It is our collective objective to provide high quality medical care, promptly delivered benefits and return the employee to the workforce. This can best be accomplished through the cooperation and collaboration of all parties including the injured employee, medical providers, claims administrator, the Agency, and PARSAC.

VII. ATTACHMENTS:

A. Cal/OSHA "Recordable" Guidelines & Definition of First Aid

B. Occupational clinic and Medical resources (provided by Agency)

C. Pre-designation of Personal Physician (DWC Form 9783)

D. Cal/OSHA "It's the Law" Required Notice

E. Workers' Compensation Claim Form (DWC-1)

F. Helios First Fill – Prescription and Employer's Medical Treatment Authorization

G. Department Incident Log

H. LWP online 5020 instructions

I. DIR Form 5020

J. Accident Investigation Forms

   1. Accident/Incident Report
   2. Department Incident Log
   3. Witness Statement

K. Sample Script of the Interactive Process

L. Online Resources (websites for PARSAC, DIR and OSHA information)

   1. Salary Continuation Form template
   2. Workers' Compensation FAQ Brochure template

M. Additional Information provided by Gerald Lenahan, Lenahan Lee Slater & Pearse, LLP:

   1. The Going and Coming Rule
   2. Business Travel
   3. Mileage reimbursement and pay for attending medical appointments, depositions, and/or court appearances
   4. Off Duty Social, Recreational, and Athletic Activity
   5. Leave of Absence and 4850 Salary: Basic Considerations

ATTACHMENT A
Cal/OSHA "Recordable" Guidelines & Definition of First Aid

Cal/OSHA defines "first aid" as any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injuries, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel. [*Labor Code 5401 (a)]*

Cal/OSHA "RECORDABLE" GUIDELINES

- Cal/OSHA "recordable" are not considered "first-aid."
- All occupational fatalities, regardless of the time between the injury and the death, or the length of illness.
- All occupational illnesses, regardless of treatment or severity.
- Lost work day injuries – a case in which the injury caused absence from work and/ or restricted activity beyond the day of the injury. Time spent obtaining medical treatment is not defined as "lost-time."
- Injuries without lost work days involving:
    a. absence from work and /or restricted work activity on the day of the injury only, other than the time spent visiting the doctor or the clinic;
    b. loss of consciousness;
    c. termination of employment;
    d. permanent transfer to another job.

<u>Medical Treatment</u>:

The following are generally considered medical treatments. *Work-related injuries for which the type of treatment was provided or should have been provided are almost always "recordable."*

- ✓ Treatment for infection;
- ✓ Application of antiseptics during second or subsequent visits to medical personnel;
- ✓ Treatment of second or third degree burn (s);
- ✓ Application of butterfly adhesive dressing(s);
- ✓ Application of sutures (stitches);
- ✓ Removal of foreign bodies embedded in eye;
- ✓ Removal of foreign bodies from wound, if procedure is complicated because of depth of embedment, size, or location;
- ✓ Use of prescription medication (except a single dose administered on the first visit for minor injury or discomfort;
- ✓ Application of hot or cold compress(es) during second or subsequent visits to medical personnel;
- ✓ Cutting away dead skin (surgical debridement);
- ✓ Application of heat therapy during second or subsequent visits to medical personnel;
- ✓ Use of whirlpool bath therapy during second or subsequent visit to medical personnel;
- ✓ Positive x-ray diagnosis (fractures, broken bones, etc.);

ATTACHMENT A
Cal/OSHA "Recordable" Guidelines & Definition of First Aid

- ✓ Use of hot or cold soaking therapy during second or subsequent visit to medical personnel; and/or
- ✓ Admission to a hospital or equivalent medical facility for treatment or prolonged observation.

The fact that an "Employer's Report of Occupational Injury or Illness" has been submitted to your worker's compensation insurance carrier does not necessarily make the case "recordable" for Cal/OSHA.

Cal/OSHA NON-RECORDABLE GUIDELINES - "FIRST-AID"

First-Aid Treatment:

The following are generally considered "first-aid" treatment (e.g. one-time treatment and subsequent observation of minor injuries) and need not be recorded if the work-related injury does not involve loss of consciousness, restriction of work or motion, or transfer to another job:

- ✓ Application of antiseptics during the first visit to medical personnel,
- ✓ Treatment of first degree burn(s),
- ✓ Application of bandages during any visit to medical personnel,
- ✓ Use of elastic bandages during the first visit to medical personnel,
- ✓ Removal of foreign bodies from wound, if procedure is uncomplicated, and is, for example, by tweezers or other simple technique,
- ✓ Soaking therapy on the initial visit to medical personnel or removal of bandages by soaking,
- ✓ Use of non-prescription medications and administration of a single dose of prescription medication on the first visit, for minor injury or discomfort,
- ✓ Application of hot and cold compress(es) during the first visit to medical personnel,
- ✓ Application of ointments to abrasion to prevent drying or cracking,
- ✓ Application of heat therapy during the first visit to medical personnel,
- ✓ Negative X-ray, diagnosis,
- ✓ Brief observation of injury during visit to medical personnel.

The administration of a tetanus or booster shot, by itself, is not considered a medical treatment. However, injuries requiring a tetanus shot may be recordable for Cal/OSHA.

ATTACHMENT B

City/Town of _____

Network of Occupational Specialist Care Providers

**** TO BE DEVELOPED AND ATTACHED BY MEMBER ****

PRINT CLEAR

ATTACHMENT C

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

_____
(name of doctor)(M.D., D.O., or medical group)

_____ (street address, city, state, ZIP)

_____ (telephone number)

Employee Name (please print):

_____

Employee's Address:

_____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee's Signature _____Date: _____

Physician: I agree to this Predesignation:

Signature: _____Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.

ATTACHMENT D

U.S. Department of Labor

OSHA®
Occupational Safety and Health Administration

Job Safety and Health
IT'S THE LAW!

All workers have the right to:

- A safe workplace.
- Raise a safety or health concern with your employer or OSHA, or report a work-related injury or illness, without being retaliated against.
- Receive information and training on job hazards, including all hazardous substances in your workplace.
- Request an OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions. OSHA will keep your name confidential. You have the right to have a representative contact OSHA on your behalf.
- Participate (or have your representative participate) in an OSHA inspection and speak in private to the inspector.
- File a complaint with OSHA within 30 days (by phone, online or by mail) if you have been retaliated against for using your rights.
- See any OSHA citations issued to your employer.
- Request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

This poster is available free from OSHA.

Employers must:

- Provide employees a workplace free from recognized hazards. It is illegal to retaliate against an employee for using any of their rights under the law, including raising a health and safety concern with you or with OSHA, or reporting a work-related injury or illness.
- Comply with all applicable OSHA standards.
- Report to OSHA all work-related fatalities within 8 hours, and all inpatient hospitalizations, amputations and losses of an eye within 24 hours.
- Provide required training to all workers in a language and vocabulary they can understand.
- Prominently display this poster in the workplace.
- Post OSHA citations at or near the place of the alleged violations.

FREE ASSISTANCE to identify and correct hazards is available to small and medium-sized employers, without citation or penalty, through OSHA-supported consultation programs in every state.

Contact OSHA. We can help.

1-800-321-OSHA (6742) • TTY 1-877-889-5627 • www.osha.gov

OSHA 3165-04R 2015

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov**.**

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

ATTACHMENT E

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
   _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

EMPLOYERS' MEDICAL TREATMENT AUTHORIZATION

Employee's Name: _____

Employer: _____

Date of Injury: _____

Part(s) of Body Injured: _____

Employer-Designated treating physician or facility: _____

_____

Authorized by: _____ Date: _____

Notice to Employee: Please take this form with you to the medical facility indicated above.

Notice to Preferred Provider: This letter will serve as approval for the above named employee to receive initial reasonable and necessary medical treatment required to cure or relieve the effects of injury on an industrial basis. The Claims Administrator indicated below reserves the right to determine reasonable and or necessary further treatment needed on an industrial basis.

Please submit the **Doctor's First Report of Occupational Injury or Illness form 5021**, medical reports and billing statements to:

LWP Claims Solutions, Inc.
P.O. Box 349016
Sacramento, CA 95854

Phone: (916) 609-3600
Fax: (408) 725-0395

HELIOS™
An Optum® Company

P.O. Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Helios, an Optum Company, has been chosen to manage your workers' compensation pharmacy benefits for LWP Claims Solutions and PARSAC. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to a Helios Tmesys network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 866.599.5426 or visit www.tmesys.com.

Questions? Need Help?

866.599.5426

tmesys®

LWP Claims Solutions	PARSAC
CARRIER/TPA	EMPLOYER

INJURED WORKER NAME

SOCIAL SECURITY NUMBER | DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: www.tmesys.com.

HELIOS™

Attention Pharmacists: Enter RxBIN, RxPCN, and GROUP. Member ID # format is the date of injury, and SSN combined as follows: YYMMDD123456789.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PARSACFF		

HELIOS™

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-48

HELIOS™
An Optum® Company

P.O. Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...
EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Helios, una compañía de Optum, ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para LWP Claims Solutions y PARSAC. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Helios Tmesys. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica a bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 866.599.5426 o visite www.tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

866.599.5426

tmesys®

LWP Claims Solutions	PARSAC
PORTADORA	EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

NUMERO DE SEGURO SOCIAL | FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite www.tmesys.com.

HELIOS™

Attention Pharmacists: Enter RxBIN, RxPCN, and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PARSACFF		

HELIOS™

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

ATTACHMENT G

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20___ ___

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name ______________________

City ______________ *State* ____________

Identify the person			Describe the case			Classify the case — CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness: (M)					
								Remained at Work									
(A) Case no.	(B) Employee's name	(C) Job title (*e.g., Welder*)	(D) Date of injury or onset of illness	(E) Where the event occurred (*e.g., Loading dock north end*)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (*e.g., Second degree burns on right forearm from acetylene torch*)	Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other record-able cases (J)	Away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
____	____	____	___/___ month/day	____	____	☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
					Page totals ➤	____	____	____	____	____	____	____ Injury (1)	____ Skin disorder (2)	____ Respiratory condition (3)	____ Poisoning (4)	____ Hearing loss (5)	____ All other illnesses (6)

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

ATTACHMENT H

California Online First Report of Injury

www.lwpclaims.com

Welcome to ClaimsLink

LWP's online loss reporting tool for our California Clients

This document is a guide for users. It is intended to offer a step-by-step guide to completing and submitting an Employer's First Report of Injury (Form 5020) using LWP's secure loss reporting portal.

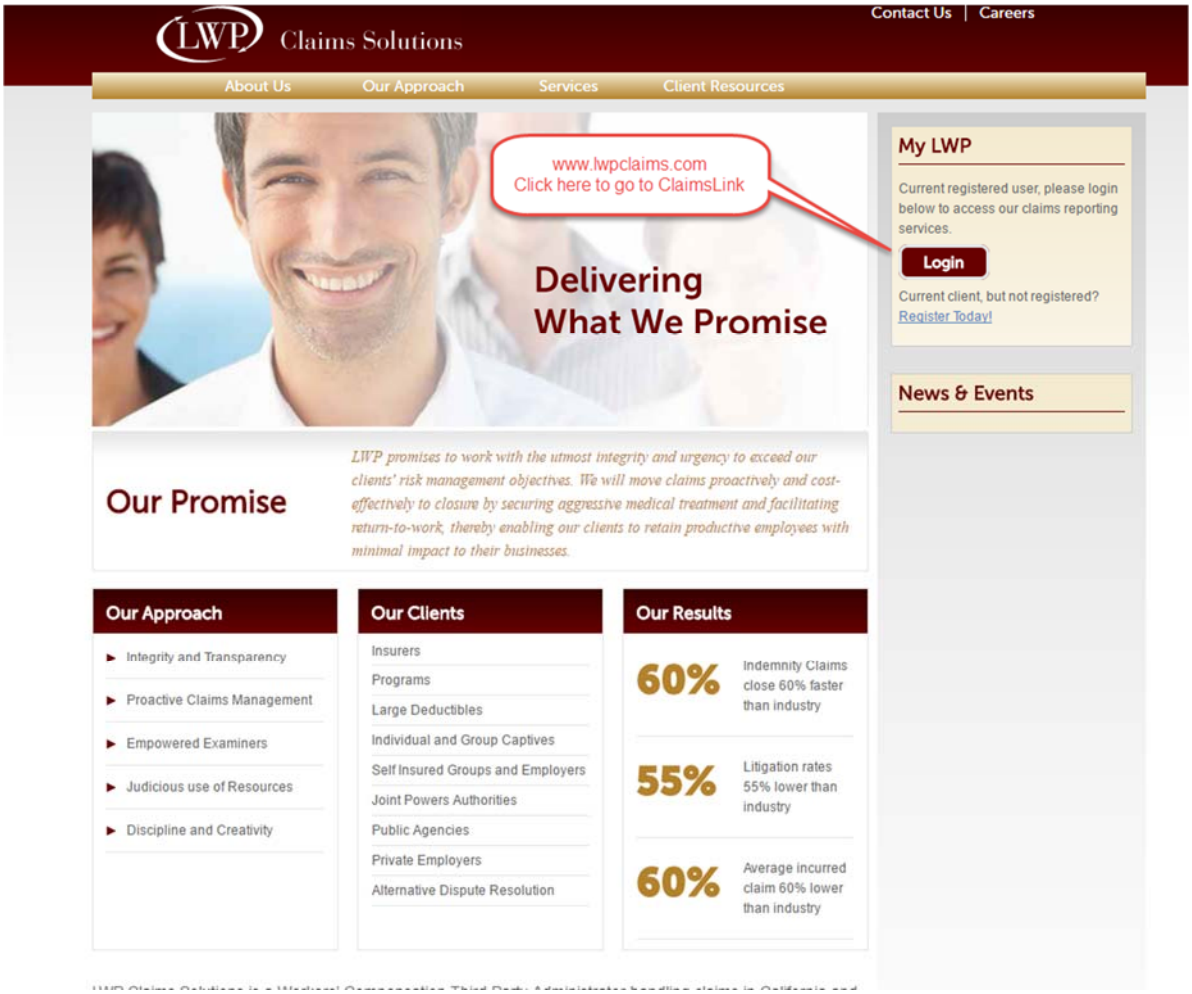
LWP will be happy to offer further assistance (including telephonic training) at any time. For training, please contact the Claims Supervisor or Manager with whom you work.

For any problems using the site, please contact LWP at lwphelpdesk@lwpclaims.com. Please describe the issue as completely as possible, so that we are prepared to assist you with a solution as quickly as possible.

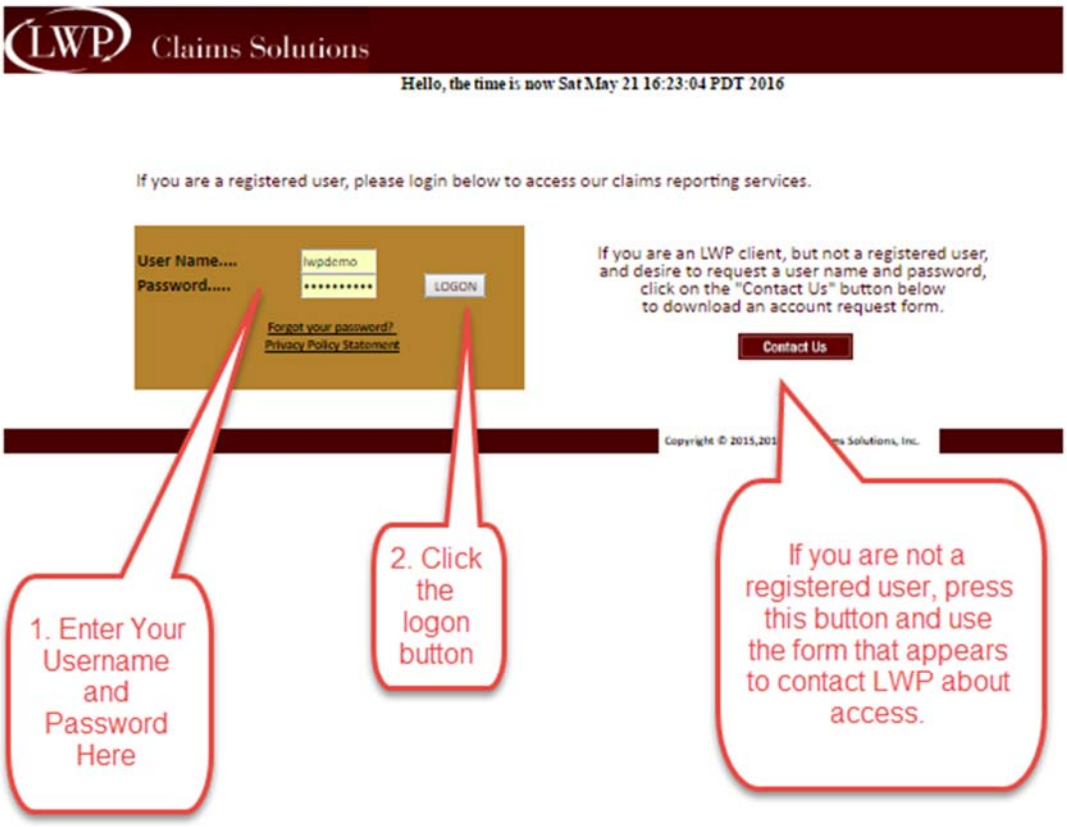
Thank you,

The LWP Team

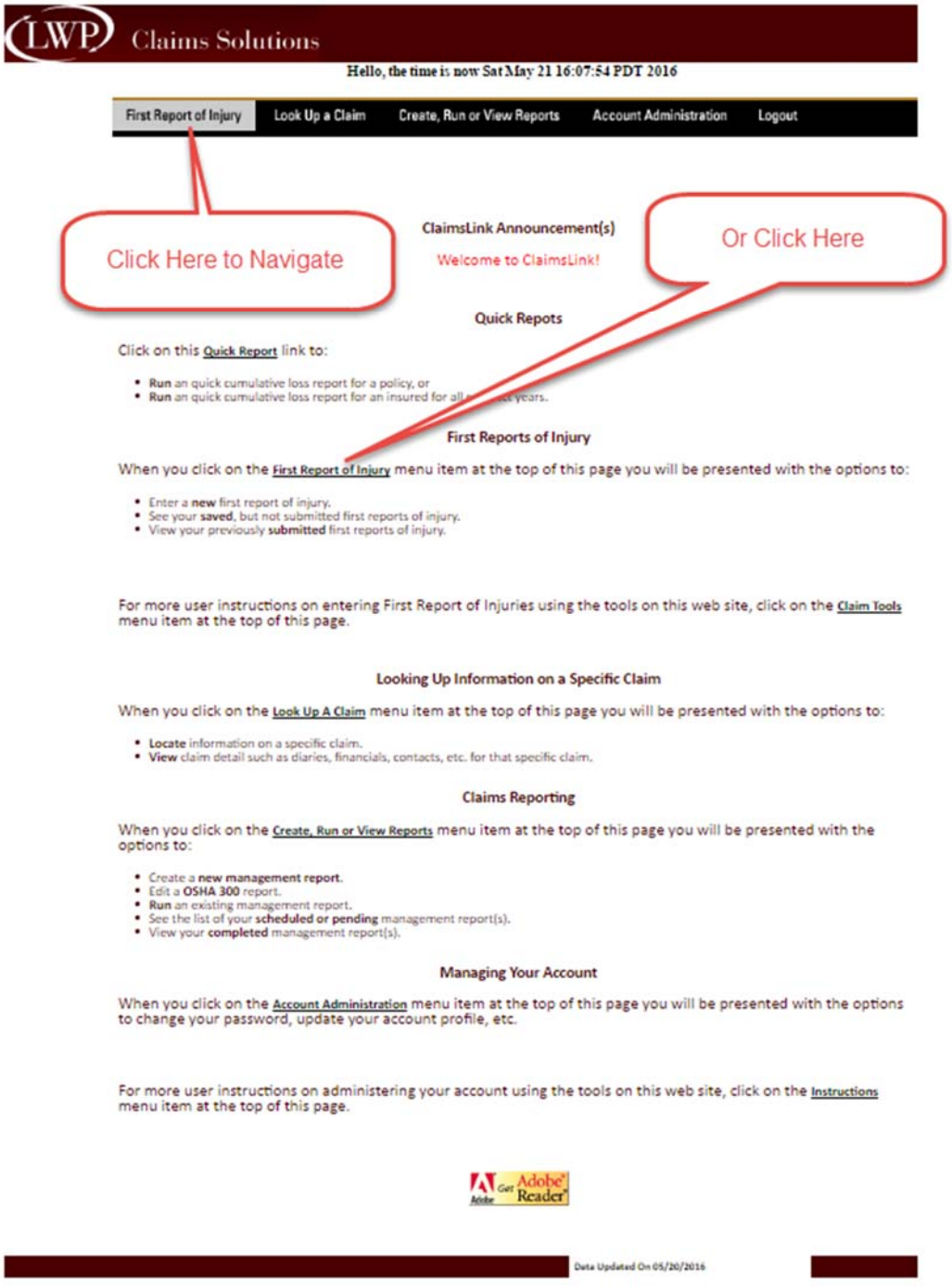
To access ClaimsLink, open the browser of your choice and navigate to www.lwpclaims.com. You should see the web page below. Click on “Login” in the “My LWP” section of the webpage.



You will be taken to the page below. If you are not a registered user, use 'Contact Us' to open an account request form that you should complete and return to us. Otherwise, please enter your username and password to Logon.



To access the Employer's First Report of Injury section of the website, click on the **First Report of Injury** link in the title bar or on the first section on the screen.

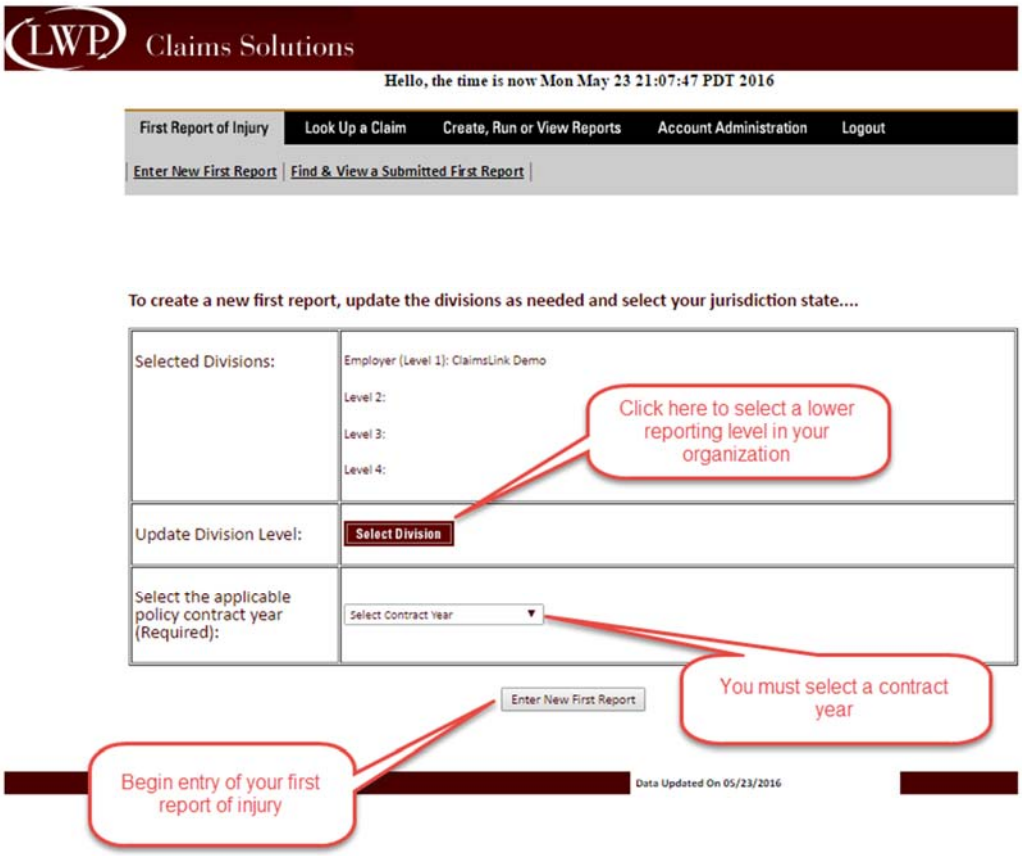


The First Report submission system is a secure way to complete and submit the First Report form. From this screen you can enter a new injury or retrieve a first report of injury that was previously submitted.

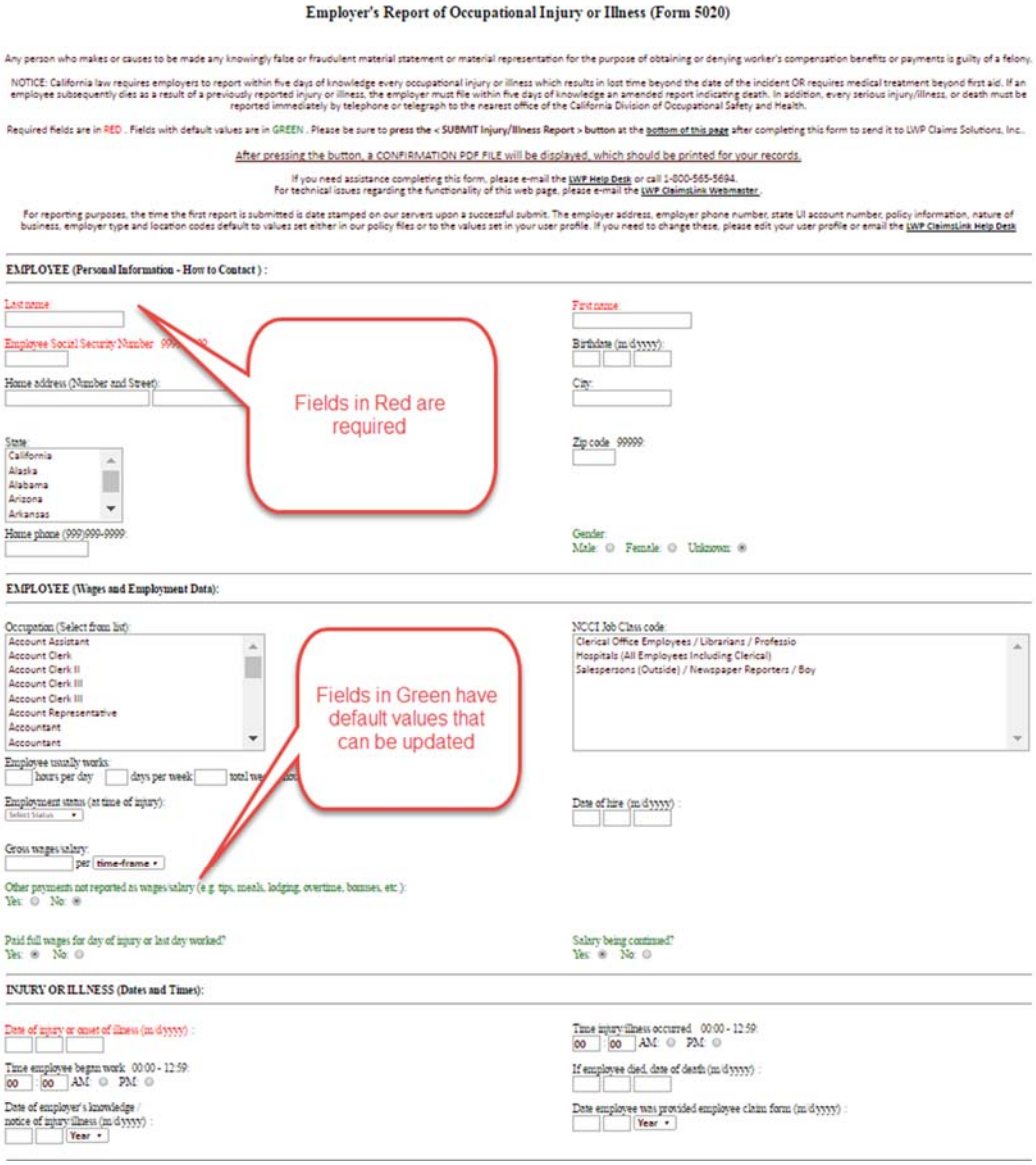
Once a first report of injury has been submitted you cannot make changes to the form. If you receive additional or corrected information please contact your Claims Examiner.

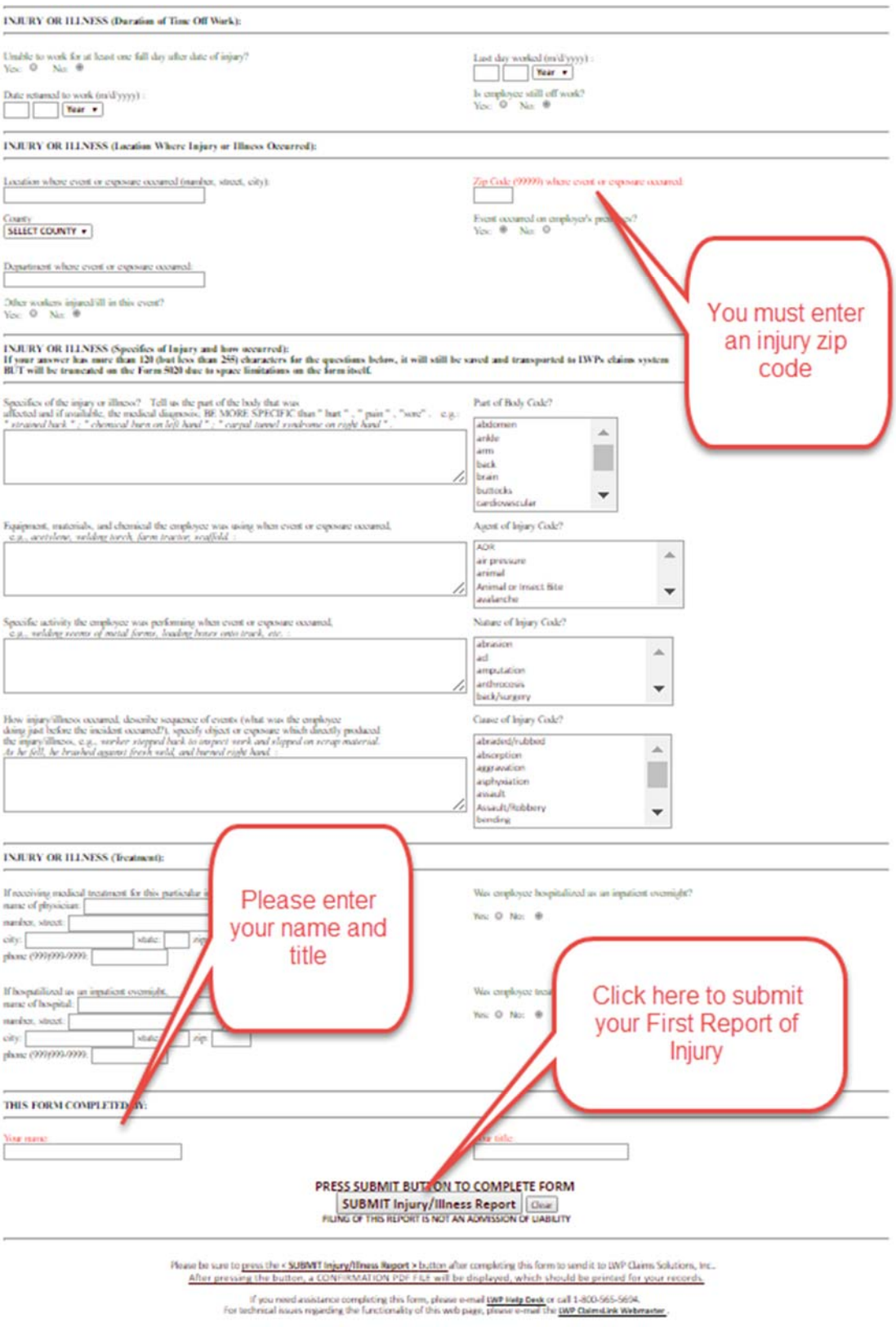
In order to begin please do the following:

1) To enter a new first report of injury, select the appropriate division level by clicking on the **Select Division** button. After you have completed the selection of the division level, click on the **Select Contract Year** and make a selection from the drop down list. Then click on the **Enter New First Report** button.
2) Select a contract year (the date of injury must be contained within the contract year)
3) Click on the 'Enter New First Report' button.



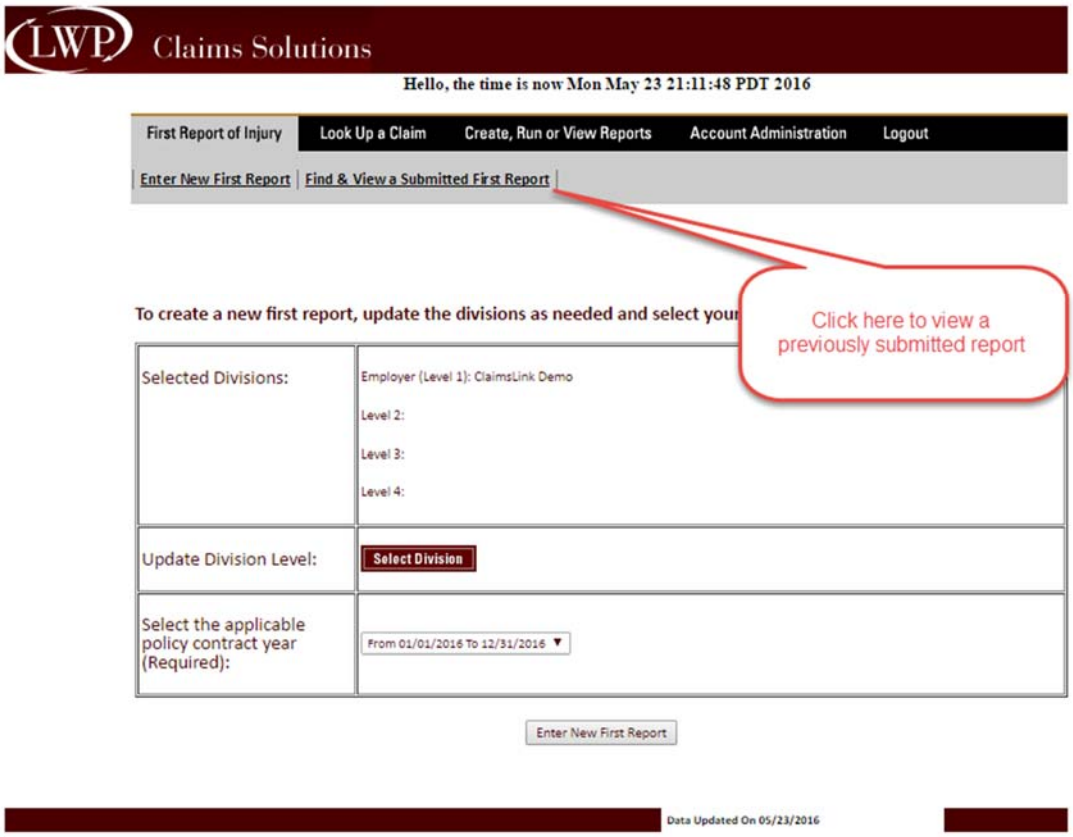
Using your tab key, fill in the information – you must, at a minimum, fill in the red highlighted boxes. Should you miss a required field, you will receive a validation edit, advising you an error. If this happens, click on the **OK** box and make the corrections. Click on the **Submit** button and the form is submitted to LWP's claims system.



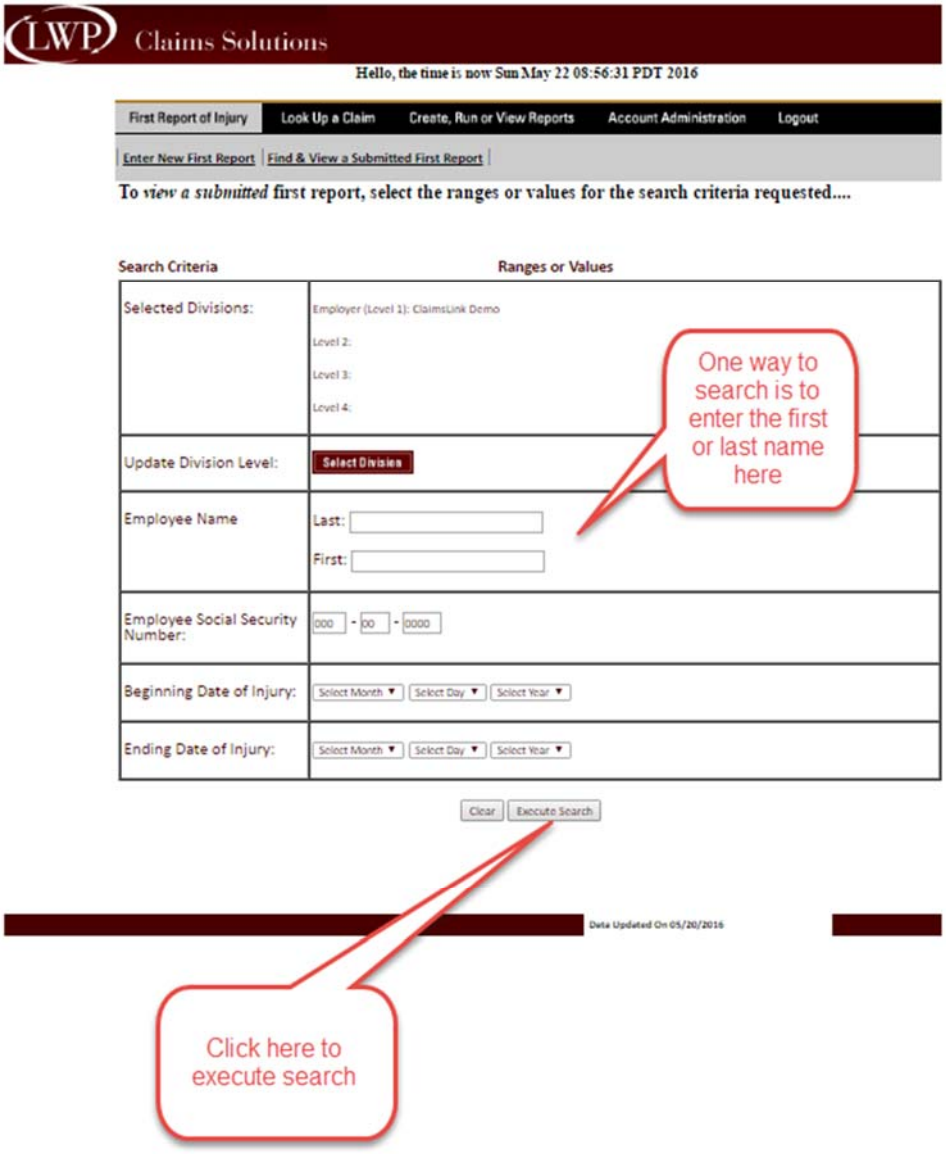

INJURY OR ILLNESS (Duration of Time Off Work):
Unable to work for at least one full day after date of injury?
Yes: No:
Last day worked (m/d/yyyy):
Year
Date returned to work (m/d/yyyy):
Year
Is employee still off work?
Yes: No:
INJURY OR ILLNESS (Location Where Injury or Illness Occurred):
Location where event or exposure occurred (number, street, city):
Zip Code (99999) where event or exposure occurred:
County:
SELECT COUNTY
Event occurred on employer's premises?
Yes: No:
Department where event or exposure occurred:
Other workers injured/ill in this event?
Yes: No:
You must enter an injury zip code
INJURY OR ILLNESS (Specifics of Injury and how occurred):
If your answer has more than 120 (but less than 255) characters for the questions below, it will still be saved and transported to LWPs claims system BUT will be truncated on the Form 5020 due to space limitations on the form itself.
Specifics of the injury or illness? Tell us the part of the body that was affected and if available, the medical diagnosis. BE MORE SPECIFIC than " hurt " , " pain " , "sore" . e.g.: " strained back " ; " chemical burn on left hand " ; " carpal tunnel syndrome on right hand " .
Part of Body Code?
abdomen
ankle
arm
back
brain
buttocks
cardiovascular
Equipment, materials, and chemical the employee was using when event or exposure occurred, e.g., acetylene, welding torch, farm tractor, scaffold. :
Agent of Injury Code?
AOR
air pressure
animal
Animal or insect bite
avalanche
Specific activity the employee was performing when event or exposure occurred, e.g., welding seams of metal forms, loading boxes onto truck, etc. :
Nature of Injury Code?
abrasion
aid
amputation
arthrocosis
back/surgery
How injury/illness occurred; describe sequence of events (what was the employee doing just before the incident occurred?); specify object or exposure which directly produced the injury/illness, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. :
Cause of Injury Code?
abraded/rubbed
absorption
aggravation
asphyxiation
assault
Assault/Robbery
bending
INJURY OR ILLNESS (Treatment):
Please enter your name and title
If receiving medical treatment for this particular i
name of physician:
number, street:
city:
state:
zip:
phone (999)999-9999:
Was employee hospitalized as an inpatient overnight?
Yes: No:
If hospitalized as an inpatient overnight,
name of hospital:
number, street:
city:
state:
zip:
phone (999)999-9999:
Was employee tre
Yes: No:
Click here to submit your First Report of Injury
THIS FORM COMPLETED BY:
Your name:
title:
PRESS SUBMIT BUTTON TO COMPLETE FORM
SUBMIT Injury/Illness Report
Clear
FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY
Please be sure to press the < SUBMIT Injury/Illness Report > button after completing this form to send it to LWP Claims Solutions, Inc..
After pressing the button, a CONFIRMATION PDF FILE will be displayed, which should be printed for your records.
If you need assistance completing this form, please e-mail LWP Help Desk or call 1-800-565-5604.
For technical issues regarding the functionality of this web page, please e-mail the LWP ClaimsLink Webmaster.

Once the “submit” button is clicked, the system will take you to a web page and ask you if would like to view the submitted first report. This page will also offer you the option to save a copy of the report.

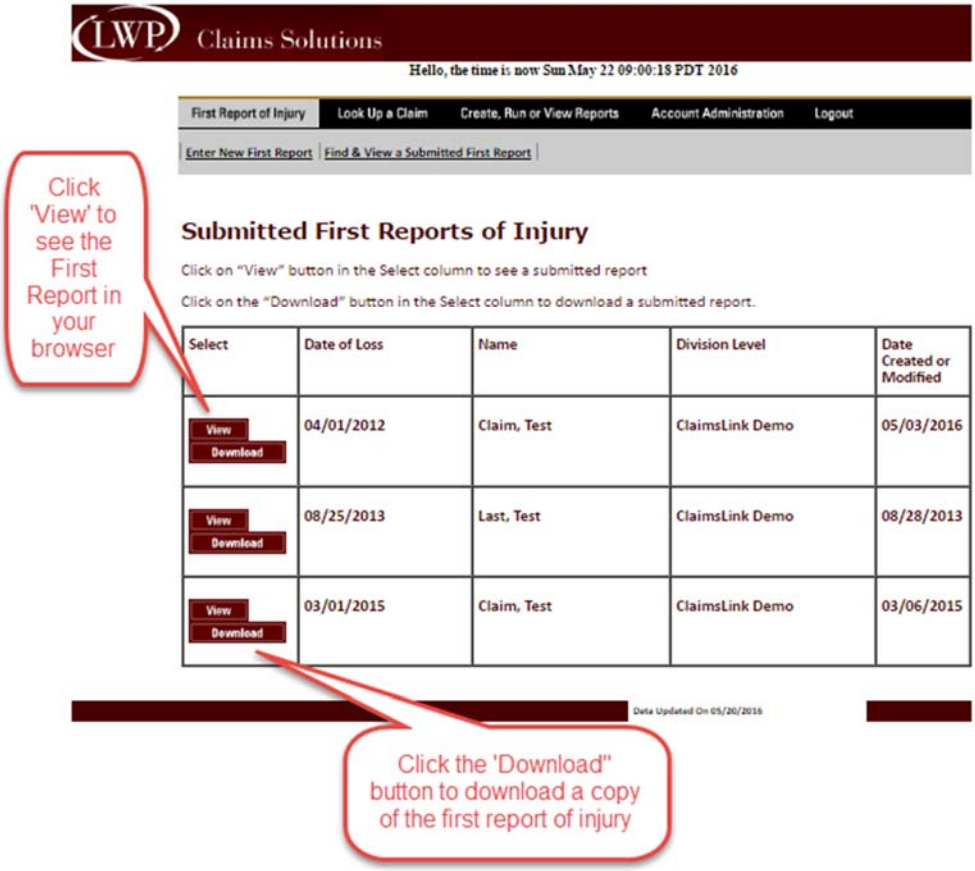
To look up a previously submitted report click on **Find & View a Submitted First Report**.



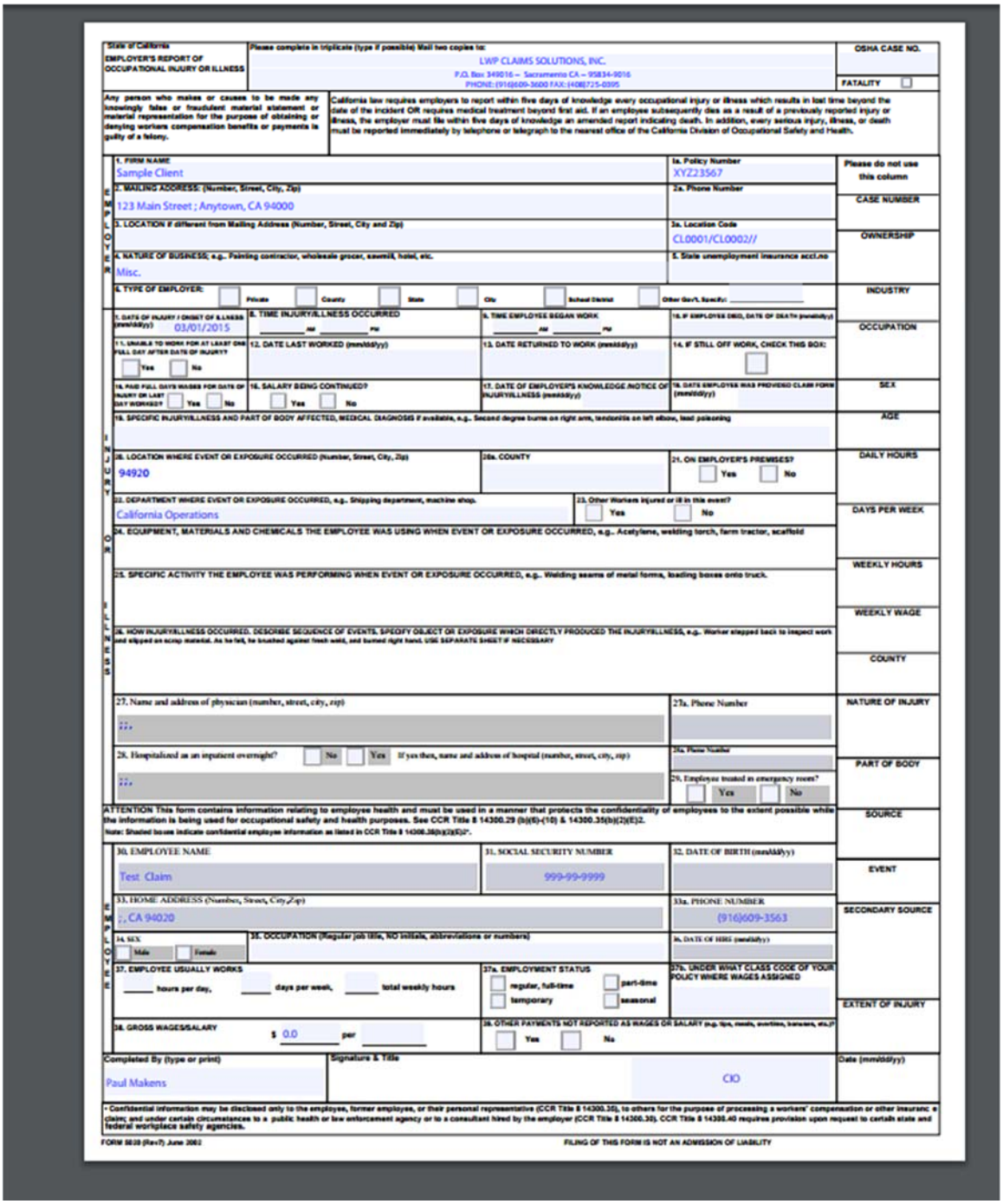
There are a number of search criteria that can be used to find the First Report that you are looking for. On this screen, you can search by name (first or last), by Social Security Number or by a range of injury dates. It is not necessary to enter the information for all fields. For example, if you only know the claimant's social security number, enter it and click "ExecuteSearch".



A list of claims that match the criteria you searched for will come up. Click “View” or “Download” to see the details of the report in PDF format.



Below is a view of a completed 5020 Form.



State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
LWP CLAIMS SOLUTIONS, INC.
P.O. Box 349016 – Sacramento CA – 95834-9016
PHONE: (916)609-3600 FAX: (408)725-0395

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: Sample Client
1a. Policy Number: XYZ23567
2. MAILING ADDRESS: (Number, Street, City, Zip): 123 Main Street ; Anytown, CA 94000
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code: CL0001/CL0002//
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: Misc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ County ☐ State ☐ City ☐ School District ☐ Other Gov't. Specify: _____

INJURY

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 03/01/2015
8. TIME INJURY/ILLNESS OCCURRED: _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK: _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYER WAS PROVIDED CLAIM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 94920
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: California Operations
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip): ,,,
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip): ,,,
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

OFFICE USE

NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Test Claim
31. SOCIAL SECURITY NUMBER: 999-99-9999
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip): , CA 94020
33a. PHONE NUMBER: (916)609-3563
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ 0.0 per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES OR SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

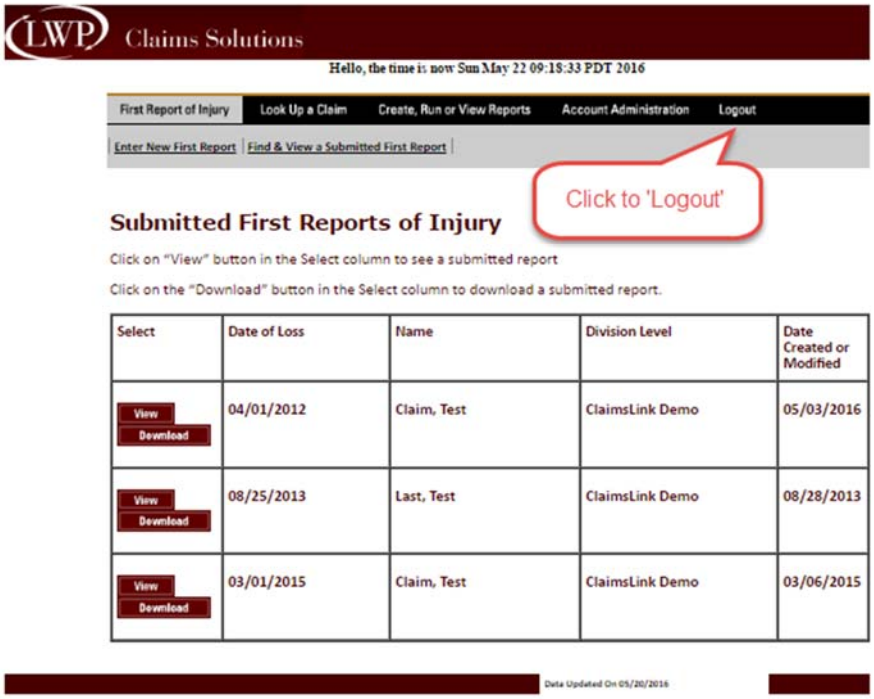
Completed By (type or print): Paul Makens
Signature & Title: CIO
Date (mm/dd/yy)

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.35). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002
FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

If you want to download the report, click 'Download'. Depending on the browser you use, you may be prompted for a save location (and possibly name) or the browser may store the report in the default download location for your MAC or PC.

To return to search, navigate back to the list of reports of injury using your browsers 'back" button or arrow. You will see the list of submitted reports again.



When you are finished working in the website click 'Logout' from the black title bar. You will be returned to the initial log in screen.

ATTACHMENT I

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME

1a. Policy Number

2. MAILING ADDRESS: (Number, Street, City, Zip)

2a. Phone Number

3. LOCATION if different from Mailing Address (Number, Street, City and Zip)

3a. Location Code

4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.

5. State unemployment insurance acct.no

6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)

8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM

9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM

10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No

12. DATE LAST WORKED (mm/dd/yy)

13. DATE RETURNED TO WORK (mm/dd/yy)

14. IF STILL OFF WORK, CHECK THIS BOX: ☐

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No

16. SALARY BEING CONTINUED? ☐ Yes ☐ No

17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)

18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)

20a. COUNTY

21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.

23. Other Workers injured or ill in this event? ☐ Yes ☐ No

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY

27. Name and address of physician (number, street, city, zip)

27a. Phone Number

28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes **If yes then, name and address of hospital (number, street, city, zip)**

28a. Phone Number

29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME

31. SOCIAL SECURITY NUMBER

32. DATE OF BIRTH (mm/dd/yy)

33. HOME ADDRESS (Number, Street, City,Zip)

33a. PHONE NUMBER

34. SEX ☐ Male ☐

35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)

36. DATE OF HIRE (mm/dd/yy)

37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours

37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal

37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED

38. GROSS WAGES/SALARY $ _____ per _____

39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)

Signature & Title

Date (mm/dd/yy)

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

ATTACHMENT J-1

ACCIDENT/INCIDENT REPORT

Event No: _____
Claim No: _____

Date of Incident: _____/_____/_____
Time of Incident: _____ a.m. p.m.
Date Reported: _____/_____/_____

_____

Incident Type:
☐ Bodily Injury/Illness
☐ Property Damage
☐ Vehicle Accident
☐ Other: _____

Personnel Information:
Last Name: _____ First Name: _____ MI: _____
Date of Birth (mm-dd-yy): ____/_____/_____ Sex ☐ M ☐ F
Home Address:_____ Home Phone: (___)_____
Work Phone: (___)_____
City: _____ State: _____ ZIP: _____

Affiliation:
☐ Employee ☐ Non Employee Department: _____
Job Title: _____ Manager or Supervisor: _____

EMPLOYEE STATEMENT

Provide a detailed description of the accident (attach additional pages if necessary):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I hereby certify that the above information is true and correct to my understanding of the incident.

_____ _____ _____
Print Name ***Signature*** ***Date***

Witness Name(s)	Statement Taken	Business Phone	Home Phone
_____	☐	(___)_____	(___)_____
_____	☐	(___)_____	(___)_____
_____	☐	(___)_____	(___)_____
_____	☐	(___)_____	(___)_____
_____	☐	(___)_____	(___)_____

ATTACHMENT J-1

ACCIDENT/INCIDENT REPORT

Event No: _____
Claim No: _____

INVESTIGATION SUMMARY

This section to be completed by Department Manager or Supervisor

Analysis: Describe the conditions and/or actions that led to the accident

Recommendations: Describe the control and/or corrective measures identified to prevent recurrence

Have these recommendations been completed? ☐ Yes, Date: _____ If not, please describe plan for correction:

Classification: ☐ First Aid ☐ Near Miss ☐ OSHA Recordable Injury / Illness ☐ Major ☐ Non-Occupational

Incident Type:	*Injury Type:*	*Body Part:*	*Illness Type:*
☐ Slip/Trip/Fall	☐ Abrasion	☐ Eye(s) – L/R	☐ Occ. Skin Disorder
☐ Struck By/Against	☐ Contusion	☐ Head/Neck	☐ Dust Disease- Lungs
☐ Caught In/Between	☐ Laceration	☐ Arm(s)/Wrist(s) – L/R	☐ Respiratory- Toxic Agent
☐ Overexertion	☐ Puncture	☐ Hand(s)/Finger(s) – L/R	☐ Systemic Poisoning
☐ Repetitive	☐ Strain/Sprain	☐ Back	☐ Blood Borne Exposure
☐ Foreign Body	☐ Fracture	☐ Trunk	☐ Other _____
☐ Hand Tool/Equipment	☐ Irritation	☐ Leg(s)/Ankle(s) – L/R	
☐ Animal/Insect Bite	☐ Burn (Thermal/Chemical)	☐ Feet/Toes – L/R	
☐ Other _____	☐ Other _____	☐ Multiple	

ATTACHMENT J -2

DEPARTMENT INCIDENT LOG

This incident log is to be used to document any and all work-related accidents or incidents that result in either a minor injury or near-miss. If the injury results in an employee having to seek medical treatment (including first-aid), the employee's manager or supervisor shall complete and submit a FIRST REPORT OF ACCIDENT/INCIDENT.

Department: ______________________________ Month:____________ 20:___

Date: ____/____/____ a.m. Time: ________ p.m.	Employee's Name: ______________________ Job Title: ______________________	Was first-aid provided to employee? ☐Yes ☐ No Did employee require additional treatment? ☐Yes ☐ No Employee obtained additional treatment from: ☐ Occ. Med Facility ☐ Personal Physician
Provide a brief description of the incident:		
Date: ____/____/____ a.m. Time: ________ p.m.	Employee's Name: ______________________ Job Title: ______________________	Was first-aid provided to employee? ☐Yes ☐ No Did employee require additional treatment? ☐Yes ☐ No Employee obtained additional treatment from: ☐ Occ. Med Facility ☐ Personal Physician
Provide a brief description of the incident:		
Date: ____/____/____ a.m. Time: ________ p.m.	Employee's Name: ______________________ Job Title: ______________________	Was first-aid provided to employee? ☐Yes ☐ No Did employee require additional treatment? ☐Yes ☐ No Employee obtained additional treatment from: ☐ Occ. Med Facility ☐ Personal Physician
Provide a brief description of the incident:		
Date: ____/____/____ a.m. Time: ________ p.m.	Employee's Name: ______________________ Job Title: ______________________	Was first-aid provided to employee? ☐Yes ☐ No Did employee require additional treatment? ☐Yes ☐ No Employee obtained additional treatment from: ☐ Occ. Med Facility ☐ Personal Physician
Provide a brief description of the incident:		
Date: ____/____/____ a.m. Time: ________ p.m.	Employee's Name: ______________________ Job Title: ______________________	Was first-aid provided to employee? ☐Yes ☐ No Did employee require additional treatment? ☐Yes ☐ No Employee obtained additional treatment from: ☐ Occ. Med Facility ☐ Personal Physician
Provide a brief description of the incident:		
Date: ____/____/____ a.m. Time: ________ p.m.	Employee's Name: ______________________ Job Title: ______________________	Was first-aid provided to employee? ☐Yes ☐ No Did employee require additional treatment? ☐Yes ☐ No Employee obtained additional treatment from: ☐ Occ. Med Facility ☐ Personal Physician
Provide a brief description of the incident:		

Manager/Supervisor Review: **Page ______ of _____**

______________________ ______________________ ______________________

Print Name ***Signature*** ***Date***

ATTACHMENT J-3

WITNESS STATEMENT

Event No: _____
Claim No: _____

Last Name: _____ First Name: _____ MI: _____

☐ Employee ☐ Vendor/Contractor ☐ Public Phone: Day_____ Evening _____

Address: _____

City:_____ State:_____ ZIP:_____

You have been identified as a witness to an accident/incident involving _____
(Employee's Name)

that was reported to have occurred on_____**.**
(Date of Accident/Incident)

Did you actually witness the accident/incident referenced above? ☐ No ☐ Yes

If yes, please provide a detailed summary of your observation of the accident/incident (attach additional pages as needed):

I hereby certify that the above statement is true and correct to the best of my knowledge. Furthermore, I have made this statement of my own free will without any prompting, urging, or influence from any other person.

_____ _____ _____/_____/_____
Print Name Signature Date

ATTACHMENT K - ADA Interactive Process

This is **one** approach to the ADA interactive process. On the employer's side of the table, you should have the TPA, supervisor, decision maker (you), and have consulted with your attorney prior to engaging in the process.

1. Review the individual's knowledge, skills and abilities as well as eligibility for positions which may be open within the organization.

2. Identify all positions which are currently open or open and available to be filled in the very near future.

3. Compare and contrast limitations as presented by the medical provider with the essential functions identified in the job description.

4. Invite the employee who has requested accommodation, or if an industrial injury, the employee who has received permanent restrictions precluding their return to pre-injury employment status to meet to discuss accommodation. *This may be done several times during the recovery process, but must be done before considering separation from employment.* The employee may be accompanied by a representative who could be a family member, attorney, or peer. The purpose of this discussion is to review those open positions and qualifications and to secure the employee's view of how you, the employer, can provide an accommodation to meet the employee's limitations.

   If the employer does not have an existing open position which meets the employee's limitations and for which the employee is otherwise qualified, there is no obligation to create a position. This interactive process allows all parties to collaborate on resolution. If it is unlikely that the employee will be returned to the workforce it's strongly advised that the employer consult with labor counsel to minimize an adverse employment action.

5. If there is agreement that an existing open position meets the employee's limitations and the employee is otherwise qualified for the position, submit the position description to the employee's physician for approval. If approved the position could be offered to the individual. In workers' comp there are a few additional hurdles regarding pay, which the TPA will assist with, but a modified or alternative job allows the employer to retain a valued member of the workforce and forgo job displacement benefits.

6. Once it is identified that there is no opportunity to continue employment, there are a number of paths to follow inclusive of job displacement benefits and claim resolution via compromise and release to resolve all outstanding issues. It's suggested that the release spell out all of the processes in plain English and offer a form of consideration ($) so that the employment relationship ends on a positive note. Labor and workers' comp defense counsel can draft that language.

ATTACHMENT L: ONLINE RESOURCES

A. PARSAC

a. Memorandum of Coverage

http://www.parsac.org/uploads/MOC_WC.pdf

b. Best Practice Templates:
http://www.parsac.org/services/bestpractices/

- Return to Work Template
- Job Descriptions & Bank of Transitional Tasks
- Election Notice for Salary Continuation (sample provided)
- Workers' Compensation FAQ Brochure (sample provided)
- ADA Accommodation Policy & Procedures
- Accident Investigation Procedures
- Facility Safety Inspection Procedures

B. California Department of Industrial Relations (DIR), Division of Workers' Compensation (DWC)

- Pre-designation of Personal Physicians (8 CCR §9780):

  http://www.dir.ca.gov/dwc/DWCPropRegs/Predesignation_Regs/FinalRegulations/Predesignation_TextOfRegs_Clean.pdf
- Disability and Mileage rates:
  http://www.dir.ca.gov/dwc/WorkerscompensationBenefits.htm
- Facts for Injured Workers:
  http://www.dir.ca.gov/dwc/InjuredWorker.htm
- Supplemental Job Displacement Benefits:

  http://www.dir.ca.gov/dwc/SJDB.htm
- Information and Assistance Offices:
  http://www.dir.ca.gov/dwc/ianda.html
- To Order "Facts About Workers' Compensation" Brochure:

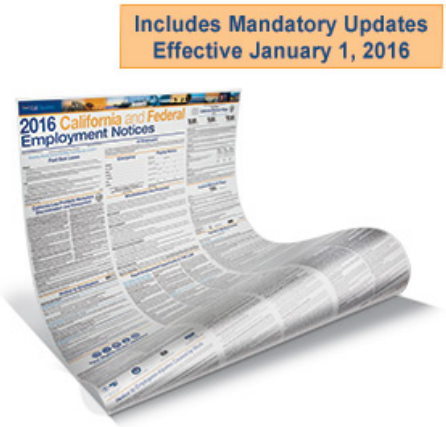
  http://www.cwci.org/store.html

C. Cal/OSHA Information

- User Guide:
  http://www.dir.ca.gov/dosh/dosh_publications/osha_userguide.pdf
- Record Keeping Tools:
  http://www.dir.ca.gov/dosh/etools/recordkeeping/index.html
- Publications and Required Notices:
  https://www.osha.gov/pls/publications/publication.html
- Directory of OSHA District Offices:
  http://www.dir.ca.gov/dosh/districtoffices.htm

D. California Chamber of Commerce

- To order California and Federal Employment Notices combined poster:



http://store.calchamber.com/products/10032178/MASTPOST/Employee-Notices-Poster

ATTACHMENT L

OPTION FOR SALARY CONTINUATION
For Work-Related Disability Leave

PURSUANT TO POLICY #_____, THE ***[CITY/TOWN]*** OF _____ PROVIDES EMPLOYEES WHO ARE OFF WORK DUE TO A WORK-RELATED INJURY THE OPTION TO CONTINUE TO RECEIVING THEIR FULL SALARY USING ACCRUED LEAVE.

A. **Election of Salary Continuation** – *Please read carefully.*

I request ***[City/Town]*** draw from my accrued leave banks an amount not to exceed my full salary when combined with temporary disability benefits issued by the workers' compensation administrator. I understand the accrued leave used to continue my salary is subject to taxes and all other deductions made to my regular income. I further understand that these deductions include my portion of benefit-related costs.

Funds will be drawn from my available sick leave first and then vacation or other accrued leave. If funds are insufficient to continue my full salary for the entire period of my temporary disability, funds will be applied until the leave bank is exhausted. I understand that once all leave is exhausted I will receive only temporary disability benefits until I either return to work or all benefits provided by law are exhausted. I further understand that in the event benefits are overpaid, whether by the Claims Adjuster or the City, I will be responsible to promptly notify the City and return the overpayment.

By signing below, I voluntarily select this option and confirm my understanding of the above.

_____ _____
Employee Signature *Print Name*

_____
Date

B. Rejection of Salary Continuation

By signing below, I confirm I have read and understand the above and do not wish to use accrued leave for salary continuation.

_____ _____
Employee Signature *Print Name*

_____
Date

Witness: _____
Name and Title

Reviewed and approved as to form and compliance with policy.
_____*, City Attorney*
Print Name:_____
Date Reviewed: _____

I was hurt at work. What should I do?

First, take care of you.

If you or a coworker is seriously injured, do not hesitate to seek emergency medical treatment. Be sure to tell ER staff the injury is work-related.

Contact your supervisor as soon as possible to report the injury. You will receive a claim form (DWC-1) and a "first fill" card so that you don't have to pay cash for your first prescription.

[AGENCY CONTACT]

MEMBER LOGO

PARSAC
PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA

Still have questions? Call us.
HR/Adjuster

Information is also available on the Department of Industrial Relations website:

http://www.dir.ca.gov/dwc/InjuredWorker.htm

Are you okay?!

A guide to frequently asked questions about Workers' Compensation

ATTACHMENT L

What is workers' compensation?

Workers' compensation benefits are set by State law and are designed to help you recover from a work-related injury or illness so that you can get back to your life.

What if my injury isn't that serious?

For every on the job injury, report it to HR/ Supervisor. Letting us know when you are hurt protects your rights, even if you don't want to go to the doctor.

Our main goal is to help you get your life back.

What doctor can I treat with?

The Claims Examiner will guide you to the best medical facility in your area qualified to treat work injuries, unless you pre-designated your regular physician (DWC-9783).

Who pays for my medical care?

There is no out-of-pocket expense to you when treating with our medical facilities. Simply complete a claim form (DWC-1) and return it to HR/your supervisor as soon as possible, but no later than 30 days.

What can I expect after I file a claim?

- Open communication with Human Resources and the Claims Examiner. We're here to help, so let us know any time you have questions or concerns.
- Medical care for the type of work-related injury or illness you have, which is guided by your doctor.
- Payments to replace most of your wages while off work (temporary disability). Ask us about options for Salary Continuation.
- Transitional work assignments (modified duty), if available. This type of work helps you receive your normal pay and recover faster. Available assignments will be based on your doctor's recommendations.

What if I disagree with my doctor?

If you disagree with your diagnosis or treatment, contact Human Resources or the Claims Examiner. You may be able to change doctors or get help from our Employee Advocate, a registered nurse who's only job is to make sure you get the medical care you need to recover fully.

What if I don't get better?

Your doctor decides when your recovery is complete. If you haven't reached your pre-injury condition, you may still be able to work with some limitations and/or you may be eligible for permanent disability benefits.

Help is just a phone call away.

What if I can't do my old job?

You may be eligible for training to help you prepare for a new position or career that matches your abilities.

When is my claim complete?

Your doctor decides when you are recovered or if there is any residual disability. Depending on the type and level of disability, the claim may conclude with a settlement or plan for future medical care.

ATTACHMENT L

THE GOING AND COMING RULE

Under the "Going and Coming Rule" an employee is not entitled to workers' compensation for injuries sustained during a local commute to a fixed place of business at fixed hours. Such injuries are deemed to be outside the course of employment. There are many exceptions to this rule. The exclusion does not apply if the employer furnishes the vehicle, if the employee is required or expected to use the vehicle for the employer's business, if the employee is reimbursed for the commute, if the employee is asked to perform a special errand, mission, or assignment for the benefit of the employer. The employee enters the "course of employment" at the time he/she arrives at the employer's premises which includes a parking facility or lot if the parking area is provided by, or paid for, by the employer.

BUSINESS TRAVEL

When an employee is sent out of town for business travel, promotion, or education, the course of employment is expanded to encompass virtually all activity unless deemed an unreasonable deviation from the legitimate business purpose of the trip. In general, travel to and from the destination, air travel, normal use of the hotel facility, attendance at lunches, dinners, cocktail parties, are all within the "course of employment" when the employee travels at the request of and for the benefit of the employer. This expanded coverage also encompasses normal and expected social, recreational, and athletic activity even if not directly related to the business purpose of the trip. An injury sustained in a business trip will only be outside the course of employment when the activity is so unusual or so unexpected as to be deemed a significant deviation from the business trip.

ATTENDANCE AT LEGAL PROCEEDINGS

If the employee/claimant is required to attend a deposition at the request of the employer, the employee is entitled to mileage reimbursement at the IRS rate, reimbursement for any loss of wages incurred during attendance at the deposition, and a reasonable allowance for the employee's attorney at a rate to be determined by the WCAB. In contrast, if an employee is required to attend a medical-legal appointment, the employee is entitled to mileage reimbursement but is only entitled to payment of one day of temporary disability indemnity for attendance at the appointment The employee is not entitled to mileage reimbursement or wage reimbursement or temporary disability indemnity to attend any other legal proceeding, including depositions of other witnesses, depositions of doctors, WCAB conferences, or trials.

OFF DUTY SOCIAL, RECREATIONAL & ATHLETIC ACTIVITY

An employee is not entitled to workers' compensation for an injury that arises out of voluntary participation in any off-duty recreational, social, or athletic activity. The injury is compensable if the employee's participation was either expressly or impliedly required by the employer. There is a two-part test to determine whether the participation was truly voluntary. The first question is subjective and requires the employee to subjectively, honestly and in good faith, believe that he/she was required or expected to participate in the activity as a part of his/her employment duties. If the employee forms the subjective belief that participation was required or expected, the second part of the test requires a determination of whether that "subjective belief" considering all of the circumstances was "objectively reasonable."

The best way to avoid liability if the employer is concerned about injuries arising out of these social, recreational or athletic activities is to have a clear statement acknowledged by the employee in writing before the event confirming that the employee's participation is completely voluntary, that the employee is free to participate or not, and that there is no detriment if the employee elects not to participate in the activity.