OAKLEY

CALIFORNIA

RETURN-TO-WORK PROGRAM

Last Revision: July 18, 2017

TABLE OF CONTENTS

POLICY STATEMENT

Employees are the City of Oakley's most valued assets. While we recognize employee safety as one of our greatest concerns and are committed to providing a safe workplace, injuries still occur. The City of Oakley strives to assist employees to return to work at the earliest possible date following an injury or illness.

The *Return-to-Work* Program has been developed with the intention of:

- Minimizing an injury's or illness's impact on the employee;
- Promoting the employee's rapid recovery from work-related injuries;
- Providing a safe and timely transition back to work; and
- Helping control the City of Oakley's workers' compensation and disability costs.

When an employee can be offered meaningful temporary work assignments through the *Return-to-Work* Program, both the employee and the City of Oakley benefit. Numerous studies have shown the sooner an injured employee can be brought back to work, the faster they will recover and be able to return to regular assignment.

PURPOSE/GOALS

Purpose of this policy is to establish a system for safely returning to work, as soon as practicable, the employees of the City of Oakley who have sustained an industrial injury or illness. The system will improve the capability of identifying and appropriately managing temporary and permanent disabilities. The program is intended to provide a transition period of temporarily modified or light duty to facilitate the employee's return to regular duty within a short period of time.

In addition to providing for employee health and wellness, this program provides compliance with California workers' compensation laws, California disability laws, and the Federal Americans with Disabilities Act (ADA), as well as the Memorandums of Understanding (MOU) between the City of Oakley and the unions representing its employees.

SCOPE/ELIGIBILITY

This program is eligible to employees who sustain industrial injuries and illnesses. Participation is mandatory. Refusal to accept transitional duty that meets the physician or medical provider's restrictions may result in the loss of entitlement to temporary disability/salary continuation benefits.

This program covers cases that involve lost time injuries, conditions with temporary medical restrictions, and when possible, non-work related cases with temporary medical restrictions. If temporary medical restrictions render the employee unable to perform some or all of their usual assignment, then modification of the position's duties or an alternate assignment may be necessary as a temporary accommodation.

Participation in the *Return-to-Work* Program is based on the following criteria:

- All full-time regular and part-time, temporary, and/or at-will employees are eligible.
- The employee's medical condition ***temporarily*** prevents the employee from performing the full range of their regular duties.
- Any workers' compensation or disability claim has been approved or is in delayed status.
- The treating physician or medical provider has determined the employee's work capacity and released the employee to transitional duty assignment.
- The treating physician or medical provider provides an estimated recovery period.
- The employee may continue to participate in the Transitional Work Program for a period of up to four months, as long as the employee is making medical progress toward recovery and return to full regular duties.
- Transitional work assignments may be extended beyond the original four months when it is determined the additional time would facilitate a return to full regular duties and would not adversely affect the City's operational goals or the objectives of the process.

RESPONSIBILITIES

Employees

Employees have the following responsibilities in regard to the *Return to Work* Program.

- Report all injuries immediately[1] to the supervisor.
- If applicable for industrial injuries, the employee is to call RN First Call at 877-854-6877 to report the incident and speak with a triage representative who will assist the employee in accessing appropriate medical treatment and gather reporting information.
- Inform the treating physician or medical provider that the City of Oakley has transitional/modified duty assignments available.
- Provide a "Return-to-Work" restriction note from the treating physician or medical provider to the Human Resources Division as soon as possible upon receipt from the physician or medical provider.
- Meet with your Supervisor to review job duties that fit within the parameters of the medically imposed restrictions.
- Sign the *Return-to-Work Agreement* document.
- Work within the restrictions specified by the treating physician or medical provider.
- Report any physical problems with the work assignment to the supervisor.
- Report to his/her own department or assigned "out of department" supervisor as appropriate at the beginning of the transitional/modified duty assignment.
- Adhere to all City of Oakley policies and procedures, including employment policies and safety rules at the location of the transitional/modified duty.
- Attend all scheduled medical appointments and keep the assigned supervisor and Human Resources Division apprised of work status.

Department Heads

Department Heads are responsible for ensuring the full cooperation of their department's managers and supervisors in the management of the City of Oakley's *Return-to-Work* program.

[1] Immediately, is defined as "as soon as the injury is known."

- Work with Human Resources to identify transitional/modified duty assignments available in the department that fit within the parameters of the medically imposed restrictions.
- Ensure managers and supervisors comply with the employee's work restrictions as outlined by the treating physician or medical provider.

Managers and Supervisors

Managers and Supervisors have the greatest opportunity to effect the successful return of the employee to full health and duties. They can ensure the safe return of the injured/ill employee by completing the following responsibilities.

- If the employee was unable to call the injury in to RN First Call, *the* supervisor should notify the Human Resources Division asap and direct the employee to call RN First Call at 877-854-6877, as soon as is practical.
- Immediately, but not more than four hours from receipt, provide the Return-to-Work (restriction) form received from the employee to the Human Resources Division.
- Work with the Human Resources to identify transitional/modified duty assignments that fit within the parameters of the medically imposed restrictions.
- Review the employee's work capacity and work with the employee and the Human Resources to advise the employee of the availability of job duties that fit within the parameters of the employee's restrictions.
- Provide daily supervision to monitor that the employee is working within the work restrictions outlined by the treating physician or medical provider.
- Report any physical difficulties the employee may have with the work assignment to the Human Resources Division for potential referral back to the treating physician/medical provider to review work restrictions.
- Maintain ongoing contact with injured workers who are currently unable to participate in the *Return-to-Work* program.
- If the injury is a work-related injury, notify the Department Head and Human Resources immediately, but not more than two hours after the refusal, if the employee refuses an approved temporary transitional/modified duty assignment for notice to the third party administrator.

Human Resources Division

The Human Resources Division facilitates of the *Return-to-Work* Program.

- Review the employee's work capacity/restrictions and work with the employee and employee's supervisor to determine the availability of job duties that fit within the parameters of the restrictions.
- Explore other departments' job assignments if there is no work within the employee's own department.
- Notify the third party administrator of the date that transitional/modified duty is available to the employee to return to work in writing and maintain a copy in the employee's file. Please note this may differ in some cases from the actual date the employee returns to work.
- Upon nearing maximum transitional/modified duty duration of four months notify third party administrator to develop a case strategy.
- Re-assess on an ongoing basis, the availability of transitional/modified duty for those cases where the employee is eligible for transitional/modified duty but none is immediately available.
- Notify the third party administrator immediately, but not more than two hours after the refusal, of the employee's refusal or lack of response to notice of approved transitional duty.
- Train department heads, managers, supervisors, and employees regarding the City of Oakley's *Return-to-Work* program at hire and periodically thereafter.
- Advise in writing, using the *Physician or medical provider's Return-to-Work Notification Letter* (see the forms in the appendix) the entity's designated industrial clinics, physicians, or medical providers of the entity's *Return-to-Work* program.
- Immediately advise department heads, managers, supervisors, employees, and third party administrators of any significant changes to the *Return-to-Work* program.

Third Party Administrators

Third party administrators should:

- Maintain contact with the injured/ill employee at least every two weeks; and

- Pay workers' compensation wage loss benefits for industrial injuries if the employee works less than their normal weekly scheduled hours.

GENERAL INFORMATION — GUIDELINES

- The treating physician or medical provider should provide an estimated period of recovery or target date for return to full duty.
- Initial duration for transitional/modified work assignment is up to 60 calendar days per injury and will be evaluated every 30 calendar days up to a maximum of four months.
- Transitional/modified duty assignments are not meant to be a permanent position. **All assignments are temporary.**
- Nothing in this policy is intended to circumvent provisions of any MOU. The provisions of this Policy are intended to supplement existing MOU provisions. Where there is any conflict between this Policy and a MOU provision, the MOU provision will prevail.

TERMINATION OF RESTRICTED DUTIES

The City Manager may terminate temporary transitional/modified duty assignments when:

- The employee is released to their usual and customary job duties by the treating physician or medical provider;
- The treating physician or medical provider determines that the employee will not be able to return to his/her usual and customary position; or
- When temporary transitional/modified duty is no longer available due to the lack of work or the exhaustion (4 months) of temporary transitional/modified duty

APPENDIX

DEFINITIONS/GLOSSARY

Essential functions: Duties considered crucial to the job the injured/ill employee wants or has. When being considered for alternative work, the injured/ill employee must have both the physical and mental qualifications to fulfill the job's essential functions.

Modified Duty (Temporary Modified Work Assignment): The employee returns to his or her original job, but the treating physician or medical provider places some physical restrictions on the employee.

Light duty (Temporary Alternate Work Assignment): The employee returns to work, but because the original job cannot be modified to conform to the physician or medical provider's restrictions, the employee performs another work assignment on a temporary basis that accommodates the injured/ill employee's abilities either in their own department or in another department (within their own bargaining unit), if available and approved by both Department Heads AND the City Manager. Assignments outside a bargaining unit will be considered on a case-by-case basis.

Non-Occupational "Injury or Illness": An injury or disease that does not arise out of employment with the City of Oakley and is not compensable under the State of California's workers' compensation laws.

Occupational "Injury or Illness": An injury or disease arising out of employment and compensable under the State of California's workers' compensation laws.

Physician or medical provider: A medical doctor, an osteopath, a psychologist, an acupuncturist, an optometrist, a dentist, a podiatrist, or a chiropractor licensed in California. The definition of personal physician or medical provider is more limited. See personal physician or medical provider.

Return-to-Work Coordinator*:* Person assigned to work with the injured/ill employee and their department to find work within the work restrictions established by the injured/ill employee's physician or medical provider.

Temporarily Partially Disabled: When an employee as a result of an injury or illness, is permitted to perform some occupational function.

Temporary Partial Disability (TPD) Benefits: Payments the injured/ill employee receives if they can do some work while recovering from a work-related injury or illness, but they earn less than before the injury.

Temporarily Totally Disabled: When an employee, as a result of an injury or illness, is medically incapable of performing any work.

Transitional Duty: Temporary job duty, within the physician or medical provider's restrictions, offered to injured/ill employees.

Work Restrictions: A physician or medical provider's description of the work the injured/ill employee can and cannot do. Work restrictions help protect the employee from further injury.

Return-to-Work **Process Flow**

The following steps outline the overall approach of the *Return-to-Work* program.

Step 1	Employee provides documentation of restrictions to supervisor and Human Resources
Step 2	Human Resources and the employee's supervisor evaluate the medically imposed restrictions and determine the availability of an acceptable temporary assignment. If the restrictions require a change from the employee's regular duties: 1st choice Modify the employee's current position to fit the restrictions; 2nd choice Temporarily assign the employee to an existing position within the employee's department or division that meets the restrictions; 3rd choice Assign alternative responsibilities within the department; or 4th choice Temporary placement in another department.
Step 3	The supervisor explains the restrictions to the employee. For all work related (industrial) injuries, the employee signs the *Return-to-Work* Agreement Form provided by the City of Oakley acknowledging he/she understands and will comply with the restrictions. The employee is then placed and observed performing duties to verify acceptability.
Step 4	The assigned supervisor checks with the employee periodically and verifies that he/she is indeed doing the assigned job within the specified restrictions. The Employee will document modified duty assignments/task on a daily basis until the authorized treating physician or medical provider releases the employee to full or regular duty.

Return-to-Work Program Announcement to Employees

The City of Oakley considers you, our employees, as our most valued assets. Your safety and well-being are a major concern for us. We strive and are committed to providing a safe workplace but, unfortunately, injuries and illnesses may occur.

If modified/transitional work is available, our *Return-to-Work* program sets forth a process for employees who are temporarily disabled by an occupational injury or illness and unable to return to regular work immediately with a smooth, timely transition through recovery and return to full regular duties.

The process involves monitoring an employee's progress and identifying transitional/modified work opportunities that are suited to physical capacity guidelines established by your medical provider. It is based upon recent medical findings that some physical and mental activity early in the healing process can actually speed recovery.

The City of Oakley will coordinate transitional/modified return to work with you. The Human Resources Division will work closely with your treating physician, the claims adjuster/nurse, and you in order to assure that you receive quality medical care, timely benefits, and a timely return to work that is as quickly as medically possible. To accomplish this we have developed a variety of transitional modified duties. These are temporary duties that, if available and meet with your restrictions, will allow you to return to gainful employment at your regular wages, and promote a rapid recovery.

These initial temporary transitional duties may be available for up to 60 days and will be evaluated every 30 days up to a maximum of four months. Upon exhausting four months of transitional duty, you may no longer be eligible for ***this*** program. However, your claim will be re-evaluated for feasibility of a return to permanent alternate or modified work if available and within your limitations.

Employees working in a transitional/modified position will be expected to adhere to the same employee policies and procedures as all City of Oakley employees.

If you have any questions regarding our *Return-to-Work* program, please contact the Human Resources Division.

Physician or Medical Provider Forms

Physician or Medical Provider's *Return-to-Work* Announcement Letter

[ ]
[ ]
[ ]

Re: Employees of _____

Dear Physician or Medical Provider:

The purpose of this letter is to inform you that we have a *Return-to-Work* program and may have a temporary transitional/modified work assignment available for our employee.

Assignments frequently can be modified to meet any reasonable restrictions set forth by you. If you feel the employee may not be able to work a full 8-hour workday, we can often provide shortened hours within the temporary assignment for limited periods of time. Therefore, we request that you provide us with the employee's work restrictions in detail using the enclosed form or a similar form that describes the physical restrictions.

We have found the longer employees stay away from work, the more difficult it becomes for them to return to the work force. This is why we do everything reasonably possible to return employees to the work site as soon as is safely practicable.

We hope you will work with us to return your patient to the workplace as soon as you feel he/she is capable. We also look forward to working with you as your patient's physical work capacity increases so that we can revise the transitional work assignments according to your evaluation.

Please call us at _____if you have any questions or would like to discuss these temporary transitional/modified work assignments further.

Thank you for your assistance.

Sincerely,

Enclosure – Physical Capabilities Form

Physical Capabilities Form

TO THE PHYSICIAN OR MEDICAL PROVIDER

The City of Oakley maintains a *Return-to-Work* Program provide a period of temporary modified or light duty to facilitate the employee's return to regular duty within a short period of time. If the employee is unable to immediately return to regular work, we will make every effort to assign transitional/modified duty within the employee's physical capabilities. Please provide the regular work release date or transitional/modified duty restrictions below.

Fax to: | Or scan and email to:

EMPLOYEE:	**DATE OF INJURY:**
OCCUPATION:	**EMPLOYER CONTACT:**

☐ Patient is released for regular work without restrictions on:

Work Activity Restricted To

General	None	<3 Hrs.	3-5 Hrs.	>5 Hrs.	<15 Min.	15-30 Min	31-60 Min.	>60 Min	Date patient can perform job requirement
Sitting									
Standing									
Walking									
Reaching									
Overhead									
Climbing									
Bending at Waist									
Kneeling									

Number of Times Weight May Be Lifted Daily

Lifting (lbs.)	None	1-10	11-25	26-50	>50
1-10					
11-25					
26-50					
>50					

	Tool, Machine, Object	Hand			Hours Per Day
		Right	Left	Both	
Sample Grasping					
Fine Manipulation					
Pushing & Pulling					

	Hand			Feet			Hours Per Day
Vehicles/Equipment	Left	Right	Both	Left	Right	Both	

☐ **Medications** (indicate if medications prescribed restrict driving or equipment use):

Physician or Medical Provider

Signature _____ Date _____

Print Name _____ Phone Number _____

Address: Street, City, Zip Code

Street _____ City _____ Zip Code _____

Physician or Medical Provider's *Return-to-Work* Reminder Letter

[ ]
[ ]
[ ]

Re: Patient [ ]

Dear Physician or Medical Provider:

On [ ] we sent a letter to you regarding the _____'s *Return-to-Work* Program. The purpose of this letter is to remind you that we may have a temporary transitional/modified work assignment available for our employee.

Please review the enclosed Job Analysis. The physical requirements of the employee's assignments can frequently be modified to meet any reasonable restrictions set forth by you. If you feel that the employee may not be able to work a full 8-hour workday, we can often provide shortened hours within the temporary assignment for limited periods of time.

We have found the longer employees stay away from work, the more difficult it becomes for them to return to the work force. We also know that it is vitally important that employees feel like a productive team member and it is important to us to maintain our most valued asset, our employees. This is why we do everything reasonably possible to return employees to the work site as soon as is safely practicable.

We hope that you will work with us to return your patient to the workplace as soon as you feel he/she is capable. We also look forward to working with you as your patient's physical work capacity increases so that we can revise the transitional work assignments according to your evaluation.

Please call me at _____if you have any questions or would like to discuss these temporary transitional work assignments further.

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Bending at Waist									
Kneeling									

Number of Times Weight May Be Lifted Daily

Lifting (lbs.)	None	1-10	11-25	26-50	>50
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11-25					
26-50					
>50					

	Tool, Machine, Object	Hand			Hours Per Day
		Right	Left	Both	
Sample Grasping					
Fine Manipulation					
Pushing & Pulling					

	Hand			Feet			Hours Per Day
Vehicles/Equipment	Left	Right	Both	Left	Right	Both	

☐ **Medications** (indicate if medications prescribed restrict driving or equipment use):

Physician or Medical Provider

Signature | Date

Print Name | Phone Number

Address: Street, City, Zip Code

Street | City | Zip Code

Return-to-Work Agreement

The *Return-to-Work* Program is designed to assist you and the organization as a whole. If you are unable to perform your regular job duties due to a work-related injury/illness, we will make every effort to provide you with work that conforms to the physician or medical provider's work restrictions, either as temporary modification of your usual job duties or alternative temporary work duties. **This program is available on a short-term basis only when the department has available work appropriate for your work restrictions. Your participation in the *Return-to-Work* Program is limited to a maximum of 90 calendar days.**

Employee:			
Assigned Supervisor:			
Restrictions:			
Usual job duty accommodations:			
Alternative job duties assigned:			
Work Schedule:			
Start Date:		**End Date:**	

EMPLOYEE INFORMATION

1. Your treating physician or medical provider has released you to perform work with restrictions as outlined above. The City of Oakley has temporary transitional duties available within these restrictions.
2. You are expected to report to work on the above start date and thereafter according to the above work schedule.
3. All regular personnel policies and procedures with respect to attendance and performance will apply as usual while you are participating in the *Return-to-Work* program.
4. If you experience an increase in symptoms while performing these duties, immediately advise your supervisor and the Human Resources Division.
5. If you are unable to perform any of your assigned temporary transitional/modified duties because of your injury, immediately advise your supervisor and the Human Resources Divison.You will need a Work Status Report/disability slip from your treating physician or medical provider to cover any lost days.
6. After each medical appointment, you will need to provide the Human Resources Division with an updated copy of a **Work Status Report** listing your restrictions.
7. A temporary/modified duty assignment is temporary and the City reserves the right to reassign and/or terminate transitional/modified duty assignments at any time.

☐ **I understand and agree to the guidelines of the *Return-to-Work* Assignment as outlined above.**

☐ **I refuse to accept the guidelines of the *Return-to-Work* Assignment as outlined above; I understand that refusal may results loss of entitled to supplemental job displacement benefits.**

Employee Signature _____ Date _____

Supervisor _____ Date _____

Distribution: Human Resources Employee Supervisor

Employee's Name: **Incident Date:**

INSTRUCTIONS TO THE SUPERVISOR – INVESTIGATION PROCEDURE

- ⇨ **Complete this report with full detail. Fax a completed copy to MPA at (925) 946-4183.**
- ⇨ Return the original completed report to your Human Resources Department within 72 Hours of the day you first became aware of the injury or illness.
- ⇨ Conduct a walk through of the accident location as needed to gain an understanding of how the incident occurred.
- ⇨ Interview and get signed statements from the injured employee and witnesses at the scene, if appropriate. Use the attached EMPLOYEE/WITNESS ACCOUNT OF ACCIDENT form.
- ⇨ Take photographs or make a sketch of the accident scene as needed, and attach to report.
- ⇨ Ensure hazardous conditions are corrected immediately. Isolate and restrict access to accident-related equipment, areas, etc, as needed.
- ⇨ **Develop appropriate corrective measures to prevent this incident from recurring, and list on this report.**

SUPERVISOR TO COMPLETE:

1. **Employee's usual shift: to (use 24 hour format, i.e. 6:00pm = 18:00)**
2. **Time employee started work on day of injury:**
3. **Time of accident/injury:**
4. **Extended shift/overtime on day of injury?** ☐ Yes ☐ No
5. **ROOT CAUSE ANALYSIS: Which of the following may have caused or were underlying factors that resulted in the incident? (Check all that apply)**

PEOPLE Factors					
☐	Employee Training / Instruction	☐	Operating without authority	☐	Correct tool not used
☐	Distraction, inattention	☐	Operating at unsafe speeds	☐	Improper Motivation
☐	Fatigue / Condition of Individuals	☐	Incorrect lifting, carrying	☐	Bypassing safety devices
☐	PPE not utilized	☐	Taking unsafe position / posture	☐	Combative Person / Actions of Others
☐	Staffing shortage	☐	Tool used improperly	☐	Other (list)

EQUIPMENT, MATERIALS or ENVIRONMENT					
☐	Lighting too much / too little	☐	Proper tool not available	☐	HVAC / ventilation maintenance
☐	Guard / safety device missing	☐	Tools / equipment malfunction	☐	Motor Vehicle maintenance
☐	Unstable load/ Storage/ Congestion	☐	Inadequate work space	☐	Walking surface unsafe
☐	PPE unavailable	☐	Chemical Used (attach MSDS)	☐	Other (list)

PROCESSES & PROCEDURES					
☐	No warning system	☐	S.O.P. not followed	☐	Inadequate Traffic Control
☐	No warning provided / posted	☐	S.O.P. contributed	☐	Operational tactics
☐	Spills, debris, housekeeping inadequate	☐	No procedure in place	☐	Other (list)

6. Do you agree with the Triage Description and Employee/Witness statements? ☐ **Yes** ☐ **No**

⇨ **If not, please describe your understanding of the events that resulted in injury or occupational illness, including tasks assigned**.

7. Were other employees also injured? ☐ **Yes** ☐ **No**

⇨ **If YES, list names**:

Corrective Action

What action will be taken to prevent recurrences of this incident? (Check as many as necessary):

☐	Request ergonomic evaluation	☐	Install, replace, adjust guards	☐	Provide/monitor protective equip
☐	Train Staff	☐	Modify, replace tools, equipment	☐	Repair (explain below)
☐	Improve emergency system	☐	Provide inspections, observations	☐	Revise equipment, layout
☐	Improve housekeeping	☐	Personal Safety Coaching	☐	Review at roll call / staff mtg.
☐	Improve job orientation	☐	Develop, revise operating procedure	☐	**No action taken/Other (explain below)**

Follow Up on Corrective Action

1. **Specific Action taken:**
   a. **Work or Purchase Order to correct condition?** ☐ **Yes – Order #:** ☐ **No**
   b. **Operating procedure change?** ☐ **Yes** ☐ **No**
   ⇨ **If YES, description:**
2. **Other Comments – explain:**
3. **PHOTOGRAPHS OR SKETCH ATTACHED?** ☐ **Yes** ☐ **No**
4. **Employee/Witness statement(s) attached?** ☐ **Yes** ☐ **No**
5. **No Action Taken – explain:**

Supervisor's Name:

Supervisor's Signature: **Date:**

Management Review – I have reviewed this report and its findings.

Division / Department Head: **Date:**

Fax a copy of the completed report to Municipal Pooling Authority 925-946-4183.

EMPLOYEE/WITNESS ACCOUNT OF ACCIDENT

Note: PRINT this form, have completed and forward along with the Accident Investigation Report.

Use one form per person – CHECK below as noted:

☐ **Injured Employee** ☐ **Witness (City/Town Employee?** ☐ **Yes** ☐ **No**

Name: _____ **Department:** _____

Today's Date: _____ **Date/Time of Accident:** _____/_____

Location of Accident: _____

Accident Description (explain in detail what you were doing immediately prior to the accident and then how you believe the accident happened):

_____
Signature

Name(s) of Other Witness(s) to Accident:

1. _____

2. _____

3. _____

ATTACH TO THE ACCIDENT INVESTIGATION REPORT

Fax a copy of the completed report to Municipal Pooling Authority 925-946-4183.

California DWC 1

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

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**.

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 em- ployer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of work- ers' compensation benefits is included as the cover sheet of this form.
You should also have received a pamphlet from your employer de- scribing workers' compensation benefits and the procedures to obtain them.

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 bene- fits or payments is guilty of a felony.

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.

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.

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.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY *EL 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*

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 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

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 ☐ 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 $_____per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
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 14300.30). 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

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