City of Oakley
On-the-Job Injury Packet (Exposure)

The on-duty-supervisor will follow the procedure outlined in the Oakley Police Department Policy & Procedure section 1008.1 relating to communicable diseases.

The following instructions should assist you with determining what course of action should be taken and what documentation needs to be completed following an on duty exposure.

Upon injury or accident, check the following as completed:

- ☐ **Life/limb threatening injuries:**
  - Call 911 to seek emergency treatment
  - Report to **RN First Call** as soon as possible **877-854-6877**
- ☐ **Non-life/limb threatening injuries:**
  - Call **RN First Call 877-854-6877** to report injury, to receive treatment advice, and medical referral, as needed.

EMPLOYEE RESPONSIBILITY:
Notify the on duty supervisor immediately. The employee will not request voluntary testing from the involved subject, but will ensure that his/her Supervisor makes this request.

SUPERVISORS RESPONSIBILITY:
Ensure that the employee was medically treated by a qualified health care provider and that decontamination measures are taken for the employee and exposed equipment.

Action Steps:

1. In accordance with Oakley Police Department Policy & Procedure section 1008.1, the supervisor should obtain a biological (i.e. blood) sample from the source of the exposure. The biological sample needs to be drawn using a "red top" vacutainer blood collection tube. This sample can be obtained via a BAD tech or any hospital. The sample should be stored in an approved method until it can be tested by the Contra Costa County Public Health.

2. **Proceed to complete the paperwork prescribed on the reverse of this page.** →

*If an injury occurs in the place of employment or in connection with employment that requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation and/or the employee suffers a loss of any member of the body or suffers and serious degree of permanent disfigurement or death report to Cal/OSHA within 8 hours by calling the District Office in Concord at 925-602-6517.

City of Oakley
On-the-Job Injury Packet (Exposure)

When the source person (exposure source) voluntarily consents to a sample complete the following:

- ☐ **Contra Costa Public Health Services Form EMS-6**
- ☐ **Consent for HIV Antibody Test**
- ☐ **Authorization to Disclose Health Information**
- ☐ Fax copies of the three forms aforementioned to the Public Health Communicable Disease Program at 925-313-6465.
- ☐ Submit the 3 forms aforementioned with the lab specimen to:
  Public Health Laboratory on the 2nd Floor
  2500 Alhambra Ave., Martinez CA

Complete the following paperwork and return to Human Resources:

- ☐ **Provide DWC-1- Workers Compensation Claim Form-**
  Must be given to employee within 24 hours. Please hand deliver. If the injured employee is not available, email DWC-1 and mail the form via certified mail within 24 hours of the date of injury. Return to Human Resources
- ☐ **Employer's First Report of Injury (5020)**
- ☐ **Accident Investigation Report**
  Complete as soon as possible following the accident. Obtain a written statement from the employee and any witnesses, if appropriate. Return to Human Resources

Complete the following paperwork and return to the Administrative Lieutenant (Exposure Control Officer):

- ☐ **State of California Report of Potential HIV Exposure to Law Enforcement Employees**
- ☐ **Petition to Order to Test Accused's Blood (Officer's Petition)**
- ☐ **Petition for Order to Test Accused's Blood (Judge's Order)**

Provide Employee with:

- ☐ **Provide brochure "Facts About Workers' Compensation" to employee**
- ☐ **His/her copy of DWC-1- Workers Compensation Claim Form**

CONTRA COSTA HEALTH SERVICES-PUBLIC HEALTH
NOTIFICATION OF POSSIBLE COMMUNICABLE DISEASE EXPOSURE
(Complete all information below – PLEASE PRINT)

PERSON POTENTIALLY EXPOSED

Name:	Work Phone ( )
Employer:	Home Phone ( )
Employer address:	

☐ Completed hepatitis B vaccination series: ☐ Partial hepatitis B series: ☐ No hepatitis B vaccinations

SOURCE PERSON FOR POTENTIAL EXPOSURE:

Name:	Home phone: ( )
Address:	

INCIDENT REPORT:

Location of Incident:	Date of Incident:
	Time of Incident:
Person transported to:	Ambulance #
	Incident #

TYPE OF EXPOSURE:

☐ Mouth to Mouth resuscitation – **without protective device**

☐ Needle stick injury - **with a used/non sterile needle**

☐ Blood or secretions splashed into → ☐ Eyes ☐ Mouth ☐ Wound

☐ Meningitis

☐ Close exposure to a person with TB → ☐ Known TB ☐ Suspected TB

☐ Other risk exposure → Please describe _____

_____

Notify Public Health (925) 313-6740 during work hours M-F 8a-5p and Fax a copy of this form to (925) 313-6465.
After hours and holidays leave a voice mail message at this same number. Public Heath will follow-up with the designated officer and/or employee during normal work hours. For urgent consults phone (925) 313-6740 to connect with the on-call Health Officer.

Precautions/equipment used during this exposure: ☐ Gloves ☐ Gown ☐ Face shield
☐ Eye protection ☐ N95 mask
☐ Other: _____

How soon after the potential exposure were you able to cleanse the exposure site? _____

Other information regarding exposure: _____

Occupational Health Provider:	Address:

Name of person completing this form: PRINT Phone

PUBLIC HEALTH FOLLOW UP:

☐ No reportable communicable disease identified in source person

☐ Recommendations given to: ☐ Employee Date: ☐ Employer Date:

Actions taken by Public Health:

☐ EMS-7 mailed to: _____ By: _____ Date:_____

☐ Other actions: _____

Public Health follow up by: Name: Phone: ( )

▲ ☐ Original to Public Health ▲ ☐ Copy to health facility receiving patient ▲ ☐ Copy to employee ▲ ☐ Copy to Infection Control Officer

Unique Office of AIDS Client number

CONTRA COSTA
HEALTH SERVICES

White: Site Copy
Yellow: CIF Copy
Pink: Client Copy

Contra Costa Health Services Public Health Division

Consent for HIV Antibody Test – Confidential

Client initials

_____ I have been informed of the differences between anonymous and confidential HIV testing. I understand that HIV positive test results and related information will be reported to the California State Department of Health Services as required by law. The information will be maintained confidentially.

_____ Giving your Social Security Number (SSN) is voluntary.

_____ I have been informed about the limitations and implications of HIV tests. I understand that an HIV test's accuracy and reliability are not 100% certain.

Client initials

Rapid Testing Only

_____ I have been informed that I will receive my initial HIV test result before I leave today. I understand that a negative test result does not require confirmation.

_____ I have been informed that a reactive rapid HIV test result must be confirmed by a laboratory-based test. I consent to give a blood or oral fluid sample for this confirmatory test if my initial test result is reactive.

I understand that this is a confidential test and that its results will be released only to those health care practitioners within the Health Services Department who are directly responsible for my care and treatment. I further understand that with the exception of specific persons as allowed by law, no additional release of the results will be made without my written authorization.

By my signature below, I acknowledge that I have been given information concerning the benefits and risks of HIV testing and have had a chance to ask questions which were answered to my satisfaction. I consent to submit a blood or oral fluid sample to be tested for HIV.

_____ _____
Date Time Signature

_____ _____
Social Security Number Printed Name (Last, First)

Client Initials **Contact Information**

_____ I understand that if I miss my follow-up appointment to learn my test results, a Health Services Department employee may attempt to contact me.

Address	City	State/ZIP Code
Home Phone	Alternate Phone	Date of Birth
Additional contact instructions:		

AUTHORIZATION FOR DISCLOSURE

I, _____ hereby authorize:

_____
(Health Care Provider)

to release to: _____
(name and title of City of Oakley staff member to receive information)

any information in your files pertaining to my medical records, including the results of my blood test to determine the presence of communicable diseases. This release is extended with full knowledge and understanding that the information is for the official use bythe Oakley Police Department.

I understand the person(s) identified above, receiving the information identified above, may not further disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specified or permitted by law.

I hereby release _____, as the custodian of
(Name and Title of City of Oakley Staff Member to Receive Information)
such records, from any and all liability for damages of whatever kind, which may at any time result to me because of compliance with this authorization and request to release information of any attempt to comply with it. Should there be any question as to the validity of this release, you may contact me as indicated below.

I further understand that I have a right to receive a copy of this authorization upon my request.

Signature	**Printed Name**
Parent or Guardian (if required)	**Date**

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

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 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.

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 NJURY 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 ☐ 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 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

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. **<u>No Action Taken</u> – explain:**

Supervisor's Name:

Supervisor's Signature: **Date:**

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

Division / Department Head: **Date:**

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

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.

Contra Costa
Superior Court
725 Court Street
Martinez, CA 94553

_____
_____
(Name and Case Number)

PETITION FOR ORDER TO TEST ACCUSED'S BLOOD
(Health and Safety Code Section 121060)

To the Clerk of the Court:

I declare under penalty of perjury that the following is accurate and true to the best of my knowledge and belief:

1. My name is _____ I am an Oakley Police Officer.
(print)

2. On (date/time) _____ the accused interfered with my official duties as a peace officer biting, scratching or transferring blood or other bodily fluids to me.

During the commission of the charge offense _____ (identify the bodily fluid involved) was transferred from the accused to me.

3. Briefly, the possible transfer of bodily fluid took place as the result of one or more of the following acts (check one or more):
   - ☐ Assault or battery
   - ☐ Resisting arrest
   - ☐ Other (describe)

   _____
   _____
   _____

4. On the basis of these facts and pursuant to Health and Safety Code Section 121065 and 121060, I request that this Court grant my petition for an order to test the accused's blood for the human immunodeficiency virus (HIV) and such other communicable diseases as the Court deems appropriate.

_____ _____
Officer's Signature **Date**

Contra Costa
Superior Court
725 Court Street
Martinez, CA 94553

_____
_____
(Name and Case Number)

PETITION FOR ORDER TO TEST ACCUSED'S BLOOD
(Health and Safety Code Section 121060)

Probable cause appearing that a possible transfer of blood, saliva, semen or other bodily fluid took place as alleged in the petition, this Court orders:

1. The defendant _____ to provide two specimens of blood, pursuant to section 121060, to test for AIDS virus and _____
_____
(Identify any of the communicable disease tests sought, e.g., syphilis, hepatitis.)

2. The blood to be transmitted to a licensed medical laboratory to test for the AIDS virus and any other above-specified communicable disease, as provided in section 121060.
3. The results of the test to be sent to:
   a. The defendant or minor;
   b. The petitioner;
   c. The victim if the prosecutor is the petitioner;
   d. The officer in charge of the facility and the chief medical officer if the defendant or minor is detained; and
   e. The employing agency, officer or entity if the petitioner is a public officer.

4. If the results of the test indicate infection with the AIDS virus or other communicable disease, the results shall be transmitted to the State Department of Health.

IT IS SO ORDERED.

_____ _____
Judge's Signature **Date**