

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**

WORKERS' COMPENSATION BENEFITS

Predesignation of Personal Physician

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

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

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

Notice of Predesignation of Personal Physician

Employee: Complete this section.

To: _____ (name of employer)

If I have a work-related injury or illness, I choose to be treated by:

Name of Doctor (M.D., D.O., or medical group) _____

Doctor's Street Address _____

Doctor's City, State, ZIP _____

_____ Doctor's Telephone Number _____

Employee Name (please print) _____

Employee's Address _____

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

_____ Date _____

Employee's Signature _____

Physician: I agree to this Predesignation:

_____ Date _____

Signature (Physician or Designated Employee of the Physician or Medical Group)

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

physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

What If There Is A Problem?

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following: **Contact the Division of Workers' Compensation (DWC) Information and Assistance (I&A) Unit.** All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.

To contact the nearest I&A Unit, go to www.dwc.ca.gov and under "Workers' Compensation programs and units", click on "Information & Assistance Unit." At this site you will find fact sheets, guides and information to help you.

Consult With An Attorney: Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may 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 website at www.californiaspecialist.org. You may get a list of attorneys from your local I&A Unit or look in the yellow pages.

Warning: Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

Additional Rights: You may also have other rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-4000.

Workers' Compensation Temporary Total Disability (TD) Benefits

FOR DATES OF INJURY ON OR AFTER:	2013	2014	2015	2016	2017	2018	2019
Maximum Weekly Benefit	\$1,066.72	\$1,074.64	\$1,103.29	\$1,128.43	\$1,172.57	\$1,215.27	\$1,251.38
Minimum Weekly Benefit	\$160.00	\$161.19	\$165.49	\$169.26	\$175.88	\$182.29	\$187.71

Workers' Compensation Maximum Permanent Disability Benefits

Disability Rating 2013-2018	2013	2014 - 2019
Below 55%	\$160 - 230	\$160 - 290
55 - 69-3/4%	\$160 - 270	\$160 - 290
70 - 99%	\$160 - 290	\$160 - 290

Death Benefits*

Maximum Aggregate Death Benefit	After 1/1/2006
Single Total Dependent	\$250,000
No total dependents and one or more partial dependent	\$250,000
Two total dependents	\$290,000
Three or more total dependents	\$320,000

Burial Expenses Paid to a Maximum of \$10,000 for injuries on or after January 1, 2013.

*Benefits paid to a totally dependent minor will be continued until the age of 18 regardless of the maximum benefit.

You can hand write the information below or you can create stickers: go to www.calchamber.com/support and click on Workers' Compensation pamphlets.

Claims Administrator _____

Address _____

City _____ State ____ Zip _____

Phone _____ Policy Expiration Date _____

Non-emergency facility _____

The employer is insured for workers' compensation by _____

(Enter "self-insured" if appropriate)

The nearest Information and Assistance Officer is located in _____

Phone _____

(To find a local office, refer to *Workers' Compensation Information and Assistance Offices* found at www.calchamber.com/wcform)

Current MPN's toll free number _____

MPN website: _____

(Enter only if employer has MPN)

You may be able to find the name of your employer's workers' compensation insurer at www.caworkcompcoverage.com.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

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Your Rights to Workers' Compensation Benefits and How to Obtain Them



CalChamber
HR Expert & Business Advocate™

This pamphlet, approved by the Administrative Director of the Division of Workers' Compensation, must be given to all newly hired employees in the State of California.

WORKERS' COMPENSATION BENEFITS

What is Workers' Compensation?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries; or -

Repeated exposures at work. Examples: hurting your wrist from using vibrating tools, losing your hearing because of constant loud noise; or -

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

Discrimination is Illegal

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

What are the Benefits?

Medical care: Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.

Temporary Disability (TD) Benefits: Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two-thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. *Temporary Disability (TD)* stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.

Permanent Disability Benefits: Payments if you don't recover completely. You will be paid every two weeks if you are eligible.

There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:

- Your doctor's medical reports
- Your age
- Your occupation

Supplemental Job Displacement Benefits: This is a voucher for up to \$6,000 that you can use for retraining or skill enhancement at an approved school; books, tools, licenses or certification fees, or other resources to help you find a new job. You are eligible for this voucher if:

- You have a permanent disability.
- Your employer does not offer regular, modified, or alternative work, within 60 days after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.

Death Benefits: Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least \$224 per week. In addition, workers' compensation provides a burial allowance.

Other Benefits

You may file a claim with the *Employment Development Department (EDD)* to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of *EDD* or go to their web site www.edd.ca.gov.

If your injury results in a permanent disability (PD) and the state determines that your PD benefit is disproportionately low compared to your earning loss, you may qualify for additional money from the *Department of Industrial Relations*' special earnings loss supplement program, also known as the return to work program. If you have questions or think you qualify, contact the Information & Assistance Unit by going to www.dwc.ca.gov and looking under "*Workers' Compensation programs and units*" for the "*Information & Assistance Unit*" link or visit the DIR web site at www.dir.ca.gov.

Workers' Compensation Fraud is a Crime

Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to \$150,000 and/or serve up to five years in jail.

What Should I Do if I Have An Injury?

Report your injury to your employer: Tell your supervisor right away no matter how slight the injury may be. Don't delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job.

If you cannot report to the employer or don't hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

You may be able to find the name of your employer's workers' compensation insurer at www.caworkcompcoverage.com. If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at www.dir.ca.gov/DLSE, as all employees must be covered by law.

Get emergency treatment if needed: If it's a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for follow up treatment.

Emergency telephone number: Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer or the workers' compensation claims administrator.

Fill out DWC 1 claim form and give it to your employer: Your employer must give you a DWC 1 claim form within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within one working day of receiving the DWC 1 claim form.

If the injury is from repeated exposures, you have one year from when you realized your injury was job related to file a claim.

In either case, you may receive up to \$10,000 in employer-paid medical care until your claim is either accepted or denied. The claims administrator has up to 90 days to decide whether to accept or deny your claim. Otherwise your case is presumed payable.

Your employer or the claims administrator will send you "benefit notices" that will advise you of the status of your claim.

More About Medical Care

What is a Primary Treating Physician (PTP)? This is the doctor

with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have an MPN.

What is a Medical Provider Network (MPN)? An MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using an MPN.

If you have not named a doctor before you get hurt and your employer is using an MPN, you will see an MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

What is Predesignation? Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill. You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the "predesignation of personal physician" form included with this pamphlet. After you fill in the form, be sure to give it to your employer.

If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing *before* you get hurt. You may use the form included in this pamphlet. After you fill in the form, be sure to give it to your employer.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after 24 visits. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to the prohibition on a chiropractor continuing as your treating physician after 24 visits include postsurgical

Notice of Personal Chiropractor or Personal Acupuncturist Predesignation Form

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

Name of Chiropractor or Acupuncturist

Chiropractor's or Acupuncturist's Street Address

Chiropractor's or Acupuncturist's City, State, ZIP

Chiropractor's or Acupuncturist's Telephone Number

Employee Name (please print)

Employee's Address

Employee's City, State, ZIP

Employee's Signature

Date

**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:	
<input type="checkbox"/> Completed hepatitis B vaccination series: <input type="checkbox"/> Partial hepatitis B series: <input type="checkbox"/> 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:	
<input type="checkbox"/> Mouth to Mouth resuscitation – without protective device <input type="checkbox"/> Needle stick injury - with a used/non sterile needle <input type="checkbox"/> Blood or secretions splashed into → <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Wound <input type="checkbox"/> Meningitis <input type="checkbox"/> Close exposure to a person with TB → <input type="checkbox"/> Known TB <input type="checkbox"/> Suspected TB <input type="checkbox"/> 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 Health will follow-up with the designated officer and/or employee during normal work hours. For <u>urgent</u> consults phone (925) 313-6740 to connect with the on-call Health Officer.	
Precautions/equipment used during this exposure: <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Face shield <input type="checkbox"/> Eye protection <input type="checkbox"/> N95 mask <input type="checkbox"/> 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:	
<input type="checkbox"/> No reportable communicable disease identified in source person	
<input type="checkbox"/> Recommendations given to: <input type="checkbox"/> Employee Date: _____ <input type="checkbox"/> Employer Date: _____	
Actions taken by Public Health:	
<input type="checkbox"/> EMS-7 mailed to: _____ By: _____ Date: _____ <input type="checkbox"/> Other actions: _____	
Public Health follow up by: Name:	Phone: ()



Contra Costa Health Services Public Health Division

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

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 by the 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 diferentes 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 lesiones por un periodo limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



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

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

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

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

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

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

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

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

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

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atiende, 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 requisitos, 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 Código 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 página 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 página Web en www.californiaspecialist.org.



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.

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.

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 División de Compensación al Trabajador al (800) 736-7401 para oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios 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 ocurrió el accidente.* _____

6. Describe injury and part of body affected. *Describe 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 administradora 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

Employer copy/Copia del Empleador Employee copy/ Copia del Empleado

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

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 <input type="checkbox"/>		
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		Please do not use this column	
	2. MAILING ADDRESS: (Number, Street, City, Zip)		2a. Phone Number			CASE NUMBER
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)		3a. Location Code		OWNERSHIP	
	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 <input type="checkbox"/> Other Gov't, Specify: _____				INDUSTRY	
	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				AGE		
INJURY	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		DAILY HOURS	
OR	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold				DAYS PER WEEK	
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.				WEEKLY HOURS	
ILLNESSES	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				WEEKLY WAGE	
					COUNTY	
				NATURE OF INJURY		
				PART OF BODY		
				SOURCE		
				EVENT		
				SECONDARY SOURCE		
EMPLOYEE	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)				EXTENT OF INJURY	
	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.						



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

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

PROCESSES & PROCEDURES		
<input type="checkbox"/> No warning system	<input type="checkbox"/> S.O.P. not followed	<input type="checkbox"/> Inadequate Traffic Control
<input type="checkbox"/> No warning provided / posted	<input type="checkbox"/> S.O.P. contributed	<input type="checkbox"/> Operational tactics
<input type="checkbox"/> Spills, debris, housekeeping inadequate	<input type="checkbox"/> No procedure in place	<input type="checkbox"/> 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):

<input type="checkbox"/> Request ergonomic evaluation	<input type="checkbox"/> Install, replace, adjust guards	<input type="checkbox"/> Provide/monitor protective equip
<input type="checkbox"/> Train Staff	<input type="checkbox"/> Modify, replace tools, equipment	<input type="checkbox"/> Repair (explain below)
<input type="checkbox"/> Improve emergency system	<input type="checkbox"/> Provide inspections, observations	<input type="checkbox"/> Revise equipment, layout
<input type="checkbox"/> Improve housekeeping	<input type="checkbox"/> Personal Safety Coaching	<input type="checkbox"/> Review at roll call / staff mtg.
<input type="checkbox"/> Improve job orientation	<input type="checkbox"/> Develop, revise operating procedure	<input type="checkbox"/> 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:



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