

Work Injury Reporting Contact Information

EMERGENCY: Dial 9-1-1
Workers' Compensation: 818-238-5010
Workers' Compensation Fax: 818-238-5019

City of Burbank Work Injury Reporting Guide for Supervisors

If an **EMERGENCY**, dial 9-1-1 immediately



Notify


Treat

Document

Communicate

Steps to take following a Work Injury

| | |
|--------------------------|--|
| <input type="checkbox"/> | Immediately respond to the employee's injury notification and render aid. IF THE INJURY IS SERIOUS OR LIFE THREATENING, CALL 9-1-1 IMMEDIATELY. |
| <input type="checkbox"/> | <p>If non-emergency medical treatment is necessary, complete the Medical Service Order (MSO) Form and direct or transport the employee to the closest pre-approved industrial medical facility.</p> <ul style="list-style-type: none"> Provide the employee a copy of the MSO Form for the treating physician. <p> Click here for a list of pre-approved facilities</p> <p>NOTE: If the injury occurs after-hours, direct or transport the employee to the closest medical facility instead of the City's pre-approved facilities (due to limited hours of operation on evenings, weekends, and holidays) and make required notifications the next regular workday.</p> |
| <input type="checkbox"/> | If the employee declines medical treatment, a Declination of Medical Treatment Form must be completed by the employee. |
| <input type="checkbox"/> | <p>You <u>must</u> notify the following of the injury as soon as possible:</p> <ol style="list-style-type: none"> Your Department Workers' Compensation Division <p></p> <p>IF THE INJURY IS SERIOUS OR LIFE-THREATENING, CONDUCT YOUR NOTIFICATIONS <u>AFTER</u> EMERGENCY RESPONDERS ARRIVE.</p> |
| <input type="checkbox"/> | As soon as practical, but no later than 48 hours after the injury, investigate the incident to determine the cause of the injury. |

| | |
|--------------------------|---|
| <input type="checkbox"/> | Within 48 hours of the injury, complete an Incident Analysis Report (IAR) – Immediate Supervisor’s Statement and Investigation Report and submit it to Workers’ Compensation. ***NOTE: You <u>must</u> complete this form even if the employee declines treatment.*** |
| <input type="checkbox"/> | Complete the Employer’s Report of Occupational Injury Form (5020) and provide it to your Department Manager for signature. Provide the executed copy to Workers’ Compensation. ***NOTE: You <u>must</u> complete this form even if the employee declines treatment.*** |
| <input type="checkbox"/> | If the employee decides to file a claim, provide the employee with the Workers’ Compensation Claim Form (DWC 1) . |
| <input type="checkbox"/> | <p>If work restrictions have been given to the employee, notify your Department Manager <u>and</u> Workers’ Compensation. Together, they will work with the Americans with Disabilities Coordinator to determine whether or not an accommodation can be made.</p> <p>If the employee is out of work, call the employee to check on his or her progress periodically. Be sure to keep Workers’ Compensation informed of all restrictions that are accommodated and any change in the employee’s status.</p> |
| <input type="checkbox"/> |  <p>RETURNING TO WORK: A medical release form from the employee’s treating physician must be provided to you <u>and</u> to Workers’ Compensation prior to returning to work. Be sure to confirm the employee’s work status with Workers’ Compensation before allowing the employee to return to work.</p> |
| <input type="checkbox"/> | <p>It is the responsibility of the employee to communicate the status of their injury. They are <u>required</u> to notify their supervisor <u>and</u> workers’ compensation of the following:</p> <ol style="list-style-type: none"> a. Work Status b. Restrictions c. Medical Appointments d. Return to Work Date / Any Restrictions and/or Accommodations e. Any Other Updates Pertaining to the Injury or Claim <p><i>***Even though the employee is required to notify, ensure a good partnership in the process by checking in with your employee and Workers’ Compensation periodically. Communication is key during this process.***</i></p> |



**Still have some questions? Our Workers’ Compensation team is happy to assist!
Give them a call at 818-238-5010.**



Send Dr's Report to
City of Burbank Risk Management
P.O. Box 6459
Burbank, CA 91510-6459

City of Burbank
Management Services Department - Risk Management

Return Completed Form to:
Workers' Compensation Administrator
Facsimile: 818.238.5019

MEDICAL SERVICE ORDER

SUPERVISOR: Fill out in detail:

DOCTOR/MEDICAL FACILITY _____

ADDRESS _____

EMPLOYEE _____ **EMPLOYEE PRS & NO.** _____

DEPARTMENT _____ DIVISION _____

JOB TITLE _____ **DATE OF INJURY** _____ Time _____

Description of Accident [include body part(s)]

| Date Issued | Hour | Supervisor | Phone |
|-------------|------|------------|-------|
|-------------|------|------------|-------|

SUPERVISOR MUST KEEP THE WORKERS' COMPENSATION ADMINISTRATOR ADVISED OF ANY CHANGES IN EMPLOYEE'S CONDITION.

PHYSICIAN'S SECTION

LIGHT DUTY/EARLY RETURN TO WORK PROGRAM

Dear Treating Physician:

The above employee is being referred to you for examination and/or treatment in accordance with Workers' Compensation laws.

The City of Burbank has a light duty/early return to work program designed to help the injured employee return to his/her work environment, but with lighter duties that coincide with his/her disability.

**Please complete this form and immediately fax it to the City of Burbank
Risk Management Department at (818) 238 - 5019 .**

1. The employee is:
- a. Able to return to **Full Duty** as of _____.
 - b. Able to return to **Light Duty** on _____ until _____.
 - c. **Temporarily Totally Disabled.**

2. Describe the Temporary Work Restrictions if any _____

3. Date and time of next appointment _____

Signed Physician _____ Date _____

Phone Number _____

Physician must complete this report at the time the employee is seen.
and return forms to Workers' Compensation Administrator or immediately after first treatment.
PLEASE READ INSTRUCTIONS ON REVERSE SIDE.

INSTRUCTIONS

EMPLOYEE:

1. Have this form signed by the treating doctor after the first treatment.
2. Request that your doctor fax form to the Workers' Compensation Administrator in Risk Management IMMEDIATELY after the first treatment.
3. If the doctor tells you that you must stay off work due to your injury, be sure he notes that on the form. If he tells you that you may work limited duty, be sure he fills in on the front of the form EXACTLY what your physical restrictions are. Every effort will be made by the City to find appropriate limited duty for you.
4. Be sure to follow the instructions of the doctor fully - 24 hours a day. Keep any further appointments he makes for you and KEEP YOUR SUPERVISOR informed as to your treatment and expected date of return to work.
5. If you are off work on the advice of the treating physician, you will be paid your regular wages up to a maximum of 6 months (1040 hours).* Thereafter the State of California disability rates apply.
6. You will receive reimbursement for medications the doctor has prescribed and mileage if you drive to and from appointments in your own car. Please tam in all requests to the Workers' Compensation Administrator with you full name, address and date of injury along with the original receipt for the prescription.

**IF YOU HAVE ANY QUESTIONS PLEASE DO NOT HESITATE TO CALL THE
WORKERS' COMPENSATION ADMINISTRATOR
IN RISK MANAGEMENT (818) 238-5010**

SUPERVISOR:

1. Be sure to describe how the accident actually occurred in the section on the front of this form, and indicate body part(s) injured.
2. If the employee returns the MSO to you, please make sure to forward it to the Workers' Compensation office. DO NOT KEEP THIS FORM IN YOUR FILE.
3. If the doctor releases the employee to return to limited duty, please coordinate with your department and the Workers' Compensation Administrator the type and duration of limited duty available.
4. If the doctor places the employee on total disability, please keep in touch with the employee. When there is a possibility that the employee will be released to either full or limited duty, provide the employee a Medical Authorization to Return to Work form.
5. The employee cannot go back on the job until the Medical Authorization Form is filled out by the treating physician, approved by the Workers' Compensation Administrator, and returned to you for your file.

* Safety members receive Labor Code 4850 benefits.



**MANAGEMENT
SERVICES**

APPROVED INITIAL CLINICS

Concentra

2550 N. Hollywood Way Suite #100
Burbank, CA 91505
Open: Monday - Friday 8:00 am - 5:00pm
Phone: 818-524-3730, Fax: 818-847-8675

Concentra - Weekends

16300 Roscoe Boulevard Suite 1-A
Van Nuys, CA 91406-1258
Open: Monday - Friday 7:00 am - 7:00 pm, Saturday - Sunday 7:00 am- 3:00
pm
Phone: 818-893-4426, Fax: 818-894-7564

If your injury/illness cannot be handled at one of the above listed Concentra locations and emergency care is needed please go to **Providence St. Joseph's** Emergency Care - Burbank.

501 South Buena Vista Street
Burbank, CA 91505
Open: 24 hours per day/7 days per week
Phone: General Line: 818-842-5111, ER 818-847-4040

If you have a claim for loss of hearing please go to **Kaiser On the Job (KOJ)** for initial evaluation.

Kaiser On-the-Job® Centers in Southern California

Antelope Valley Area

Lancaster/Antelope Valley
Medical Offices
43112 N. 15th St. West
Lancaster, CA 93534
(661) 726-2262

Baldwin Park Area

Crossroads Parkway Medical Offices
12801 Crossroads Parkway South
City of Industry, CA 91746
(562) 463-4357

Bellflower Area

Orchard Medical Offices
Building D, Suite 133
9449 E. Imperial Highway
Downey, CA 90242
(562) 657-2200

Inland Empire Area

Fontana Medical Center
Medical Office Building 2, 6th Floor
9961 Sierra Ave.
Fontana, CA 92335
(909) 427-3917

Riverside Medical Center
Medical Office Building 1,
4th Floor, Module 4J
10800 Magnolia Ave.
Riverside, CA 92505
(951) 353-4322

Kern County Area

Stockdale Medical Offices
3501 Stockdale Highway
Bakersfield, CA 93309
(661) 398-3813

Los Angeles Metro Area

Culver Marina Medical Offices
12001 W. Washington Blvd.
Los Angeles, CA 90066
(310) 915-4400

Inglewood Medical Offices
110 N. La Brea Ave., 3rd Floor
Inglewood, CA 90301
(310) 419-3358

Los Angeles Medical Center
1526 N. Edgemont St., 1st Floor
Los Angeles, CA 90027
(323) 783-6621

West Los Angeles Medical Center
5971 Venice Blvd., 4th Floor
Los Angeles, CA 90034
(323) 857-3908

Orange County Area

Anaheim Medical Center
411 N. Lakeview Ave.
Anaheim, CA 92807
(714) 279-5500

Harbor–MacArthur Medical Offices
3401 S. Harbor Blvd.
Santa Ana, CA 92704
(714) 830-6660

San Diego County Area

Otay Mesa Outpatient Medical
Center
4650 Palm Ave., 1st Floor
San Diego, CA 92154
(619) 662-5006

San Diego Medical Center
4647 Zion Ave., 1st Floor
San Diego, CA 92120
(619) 528-5062

San Marcos Outpatient Medical
Center
400 Craven Road
San Marcos, CA 92078
(760) 510-5350

San Fernando Valley Area

Panorama City Medical Center
North 2 Building, 1st Floor
13652 Cantara St.
Panorama City, CA 91402
(818) 375-2233

Woodland Hills Medical Center
Northside Medical Office Building,
Entrance 10, 1st Floor
5601 De Soto Ave.
Woodland Hills, CA 91367
(818) 719-3006

South Bay Area

South Bay Medical Center
Normandie North II Building, 1st
Floor
25965 S. Normandie Ave.
Harbor City, CA 90710
(310) 517-3739

CITY OF BURBANK

DECLINATION OF MEDICAL TREATMENT

EMPLOYEE TO FILL OUT AND SIGN. SUPERVISOR TO SIGN.
PLACE IN EMPLOYEE'S DEPARTMENT FILE.

THIS FORM IS TO BE ISSUED BY THE SUPERVISOR IN THE EVENT THAT A MINOR INDUSTRIAL INJURY HAS OCCURRED AND IMMEDIATE MEDICAL ATTENTION APPEARS **NOT** TO BE WARRANTED. IT IS THE SUPERVISOR'S RESPONSIBILITY AND DECISION AS TO WHETHER THE EMPLOYEE IS SENT FOR IMMEDIATE MEDICAL ATTENTION, NOT THE EMPLOYEES.

EMPLOYEE'S NAME: _____

EMPLOYEE'S CLASSIFICATION: _____

EMPLOYEE'S DIVISION: _____

DATE OF INJURY: _____ TIME OF INJURY: _____

DESCRIBE INCIDENT AND TYPE OF INJURY: _____

I HAVE BEEN ADVISED THAT I HAVE THE RIGHT TO MEDICAL TREATMENT FOR THE INDUSTRIAL INJURY THAT HAS OCCURRED. HOWEVER, AT THIS TIME, WITH THE ACKNOWLEDGEMENT OF THE SUPERVISOR, I HAVE CHOSEN TO DECLINE MEDICAL TREATMENT. THE SIGNING OF THIS FORM DOES NOT CONSTITUTE SIGNING AWAY MEDICAL TREATMENT RIGHTS SHOULD MEDICAL TREATMENT BE REQUIRED IN THE FUTURE.

IN THE EVENT THAT IT IS A QUESTIONABLE INJURY, THE SUPERVISOR SHOULD CALL RISK MANAGEMENT/WORKERS' COMPENSATION AT (818) 238-5010 FOR FURTHER DIRECTION.

EMPLOYEE'S SIGNATURE

DATE

SUPERVISOR'S SIGNATURE

DATE

DISTRIBUTION:
RISK MGMT - Original
SAFETY - Copy

ORIGINATING DEPT. - Retain Copy

City of Burbank
Management Services Department -- RISK MANAGEMENT
INCIDENT ANALYSIS REPORT
IMMEDIATE SUPERVISOR'S STATEMENT
AND INVESTIGATION REPORT
SECTION I

TO BE COMPLETED
WITHIN
48 HOURS
BFD: BY END OF SHIFT

| TYPE OF INCIDENT | REPORT NUMBERS | | |
|--|------------------|------------------------|--------------------|
| <small>Check ALL Appropriate Boxes</small> | | | |
| <input type="checkbox"/> Non-Injury | Damage No. _____ | Date of Incident _____ | Hour _____ |
| <input type="checkbox"/> Injury | Osha No. _____ | Equipment No. _____ | (if applicable) |
| <input type="checkbox"/> Illness | Police No. _____ | PRS _____ | Employee No. _____ |
| <input type="checkbox"/> Vehicular | | | |
| <input type="checkbox"/> Equipment | | | |
| <input type="checkbox"/> Liability | | | |
| <input type="checkbox"/> Other _____ | | | |

1. NAME OF EMPLOYEE INVOLVED

| | | | |
|------------------------------|-------------|----------------------|---|
| Last _____ | First _____ | Middle Initial _____ | Years with City _____ |
| | | | Years with Department _____ |
| 2. Department/Division _____ | | | Current Assignment _____ |
| Job Title _____ | | | x Perm. <input type="checkbox"/> Temp. <input type="checkbox"/> _____ |

1. NAME OF CITIZEN INVOLVED (If more than one, attach information on additional sheet)

| | | |
|---------------------------|-------------|----------------------|
| Last _____ | First _____ | Middle Initial _____ |
| 2. Address (Street) _____ | | |
| City _____ | State _____ | Zip _____ |
| Phone (____) _____ | | |

SECTION III

10. Date & Time of Incident _____ Incident reported to _____
Date & Time Incident was reported _____
Location of Incident _____

11. A) Witnesses (If applicable)

1. Name _____ Address or Department _____ Phone Number _____

Statement: _____

2. Name _____ Address or Department _____ Phone Number _____

Statement: _____

(If more than two, attach additional sheet with information)

B) Was another person responsible for this incident? If so, whom? (Indicate name, address, phone number, driver's license and vehicle plate number.)

Section III Continued

12. A) What was the nature of the injury/illness and part(s) of body affected or vehicular damage?

B) Number of prior incidents to these part(s) of body or vehicular damage incidents _____

C) Did the employee **not** report to work on his/her next scheduled shift after the incident? _____

B) Describe the incident causing injury/illness or damage.
(Include object, substance, exposure or bodily motion (agent) which directly caused injury/illness.)

14. A) State condition and type of safety equipment and/or other equipment that was being used to perform job task.
(include vendor name and model number if known.)

B) Give detail of any damage(s) to City property involved.

15. What is your opinion as to the cause of the incident and what were the contributing factors?
(Preventable and non-preventable, unsafe act and/or condition.)

16. State your recommendation (s) and/or action(s) taken to prevent a reoccurrence.

A complete analysis of the circumstances and facts related to this accident has been made and reflects our best judgment, the corrective action stated in 16. will be reviewed for implementation.

Immediate Supervisor
Date

Division Manager
Date

Comments:

Department Manager
Date

| | | | | | |
|--|--|---|---|--|-------------------------------|
| 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 | | |
| | 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 | |
| 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 | |
| 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 | |
| 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 | |
| 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*. | | | | SOURCE | |
| | | | | EVENT | |
| | | | | SECONDARY SOURCE | |
| 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers) | | | | | |
| 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 | | EXTENT OF INJURY | |
| 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. | | | | | |



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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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 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. Check if you agree to receive notices about your claim by email only. *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____
- You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

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

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL 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



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. Use the attached form to file 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 you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who 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 is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to \$10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

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. Utilice el formulario adjunto 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 usted presenta un reclamo, el administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende (Primary Treating Physician- PTP) es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN*) o una Organización de Cuidado Médico (*Health Care Organization- HCO*), en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da 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 está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta \$10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o PTP:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

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.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. 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.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

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 serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su PTP sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una MPN, HCO o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su PTP, puede solicitar una revisión médica independiente (*Independent Medical Review-IMR*), utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la IMR es parecido al proceso de la IMR de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la IMR. La IMR no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su PTP en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesga perder el derecho a objetar a la opinión de su PTP a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado (*Qualified Medical Evaluator-QME*) para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado (*Agreed Medical Evaluator- AME*). Si el administrador de reclamos no está de acuerdo con su PTP sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un QME o AME.

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. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos 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 puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other 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.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or 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) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

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 website at www.californiaspecialist.org.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo (Supplemental Job Displacement Benefit- SJDDB): Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisitos, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

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

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (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.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o 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 (*State Disability Insurance-SDI*) o beneficios del desempleo (*Unemployment Insurance- UI*). Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia (Information & Assistance- I&A): Los Oficiales de Información y Asistencia (*I&A*) estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

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, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.