CHAPTER 10

HOW TO FILE A WORKERS' COMPENSATION CLAIM

AND

REPORTING ON-THE-JOB INJURIES AND ILLNESSES

SHASTA COUNTY RISK MANAGEMENT

Supervisor's Incident/Injury Checklist

When an Employee has an incident that may have resulted in a work-related injury, the Employee will report to their Supervisor. The Supervisor must follow this checklist to ensure that all appropriate and necessary actions have been taken.

- ❒ If it is an emergency, call 911.
- ❒ If it is not an emergency, ask the Employee if they want (non-emergency) medical treatment.
  - ❒ If **NO**, complete the ***Declination of Medical Treatment Form*** with the Employee. Please keep this form in case the employee decides to seek treatment at a later date.
    - Complete Supervisor's Incident Report.
  - ❒ If **YES**, give the employee the claim form packet and together with the employee complete the ***Claim Form (DWC-1)***, and distribute forms according to Packet instructions.
    - Send or take the Employee to the clinic or pre-designated physician for treatment.

FOLLOW UP OVERVIEW:

After each medical appointment, the Employee will provide his/her Supervisor with Work Restrictions provided by the physician. The Supervisor will take appropriate action depending on the Employee's work status:

A. If the Employee is released to Usual & Customary position (full duty):
- The Supervisor will advise the Employee to return to work.
- The Employee will return to the Treating Physician for any indicated follow-up appointments. Attempts should be made to schedule any appointments around the Employee's work shifts.

B. If the Employee has any work restrictions:
- The Supervisor, (with support as needed from Personnel and/or departmental upper management), will facilitate an interactive accommodation meeting with the Employee to determine if an appropriate temporary transitional assignment is available. If an assignment is available, all parties will review and sign the Work Accommodation Meeting agreement. The Supervisor shall forward a copy of the agreement to Risk Management. Call Support Services Director/Assistant Director, with any questions or for assistance with this agreement.
- If a Transitional Assignment is not available, the Supervisor will telephone Risk Management immediately.

C. If the Employee is Totally Temporarily Disabled:
- If the Employee is unable to return to any assignment within the department, please inform Risk Management as well as the appropriate department management and Personnel. An accommodation meeting may be held with Personnel to determine if restrictions may be accommodated within other County departments. If not, then FMLA/CFRA documents may be required at this time. In addition, as updates are received regarding work restrictions, it may be necessary to communicate with the injured worker to discuss work status.

D. If the Employee is Permanently Disabled:
- If the Employee becomes permanently unable to return to the Usual & Customary position, the Supervisor will contact Risk Management who will initiate an interactive process with the Employee to identify a Modified or Alternative placement within the County as available.

(This page can be laminated for use as a convenient reference tool in an office or off-site environment. Include the following page on the back of this laminated page for easy reference in the event that Cal/OSHA needs to be notified.)

Serious Injury/Illness/Death

In accordance with §342(a), Title 8, California Code of Regulations, employers must immediately report to the nearest District Office of the Division of Occupational Safety and Health any serious injury or illness, or death, of an employee occurring in a place of employment or in connection with any employment.

The Cal/OSHA definition of serious injury or illness is found in §330(h), Title 8, CCR:

> "Serious injury or illness" means any injury or illness occurring in a place of employment or in connection with any employment that requires inpatient hospitalization for other than medical observation or diagnostic testing, or in which an employee suffers an amputation, the loss of an eye, or any serious degree of permanent disfigurement, but does not include any injury or illness or death caused by an accident on a public street or highway, unless the accident occurred in a construction zone.

See Report a Work-Related Accident for information regarding actions to take.

I. Gather the following information:

a. Time and date of accident/event
b. Employer's name, address, and telephone number
c. Name and job title of the person reporting the accident
d. Address of accident/event site
e. Name of person to contact at accident/event site
f. Name and address of injured employee(s)
g. Nature of injuries
h. Location where injured employee(s) was/were taken for medical treatment
i. List and identity of other law enforcement agencies present at the accident/event site
j. Description of accident/event and whether the accident scene or instrumentality has been altered.

II. Then report to Redding District Office one of two ways:

a. Call: 530-224-4723 (document date and time)

b. Or email to: caloshaaccidentreport@tel-us.com

Questions: Cal/OSHA Consultation: 800-963-9424
Redding District Office
381 Hemsted Drive
Redding, CA 96002

III. Then contact: **Shasta County Risk Management**
1450 Court Street, Room 348
Redding, CA 96001
(530) 225-5141

INSTRUCTIONS FOR COMPLETING
DECLINATION OF MEDICAL TREATMENT (DMT)

This packet is for use ONLY if the Employee DECLINES medical treatment at time of injury.

If the employee is seeking treatment from either a pre-designated physician or the county designated medical facility they must complete a Workers' Compensation Claim Form – DWC-1.

Employee: ☐ Complete and sign the top portion of the **Declined Medical Treatment form.**

Supervisor and/or Department Workers' Compensation Coordinator:

- ☐ **Review and complete the supervisor section of the Declination of Medical Treatment form.**
- ☐ **In Addition, complete and sign the bottom portion of the Supervisor's Incident Report**.
- ☐ **Have each witness complete and sign a written witness statement, if applicable.**
- ☐ Send completed "original' Declination of Medical Treatment form, Supervisor's Incident Report and witness statements to your department's Workers' Compensation Coordinator for review.
- ☐ Retain a copy of the Declination of Medical Treatment form, Supervisor's Incident Report and witness statements in your department's personnel medical only folder.
- ☐ After all documents have been reviewed by the department's Workers' Compensation Coordinator, all original documents are to be forwarded to Risk Management.
- ☐ No further action is necessary at this time.

If the employee needs or requests medical treatment in the future:

- Employee and Supervisor complete a Workers' Compensation claim packet including the DWC-1 Claim Form.
- Include a copy of the Declination of Medical Treatment forms that were completed prior for the same incident.

Contact Risk Management at (530) 225-5141, with any questions related to the Declination of Medical Treatment forms process.

Employee & Supervisor Complete

SHASTA COUNTY RISK MANAGEMENT

INCIDENT REPORT AND CHECKLIST: DECLINED MEDICAL TREATMENT

This form should be completed ONLY if the Employee does not need (or request) medical treatment. If the Employee will go to either a designated medical facility or the pre-designated physician, the Claim Form Packet must be completed instead of this Declination of Medical Treatment Report.

"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 is guilty of a felony." *This notice has been approved by the Administrative Director of the Division of Workers' Compensation (California Labor Code Section 5401.7)*

EMPLOYEE COMPLETE THIS SECTION OF THE FORM

Use the back of this form and additional sheets as necessary to obtain and record all pertinent information

EMPLOYEE NAME:		Gender: ☐M ☐F	☐FULL TIME ☐PART TIME
JOB TITLE:		DEPARTMENT:	
INCIDENT DATE:	TIME OF INCIDENT:	LOCATION OF INCIDENT (building location, department, etc.):	
DATE REPORTED:	TIME BEGAN WORK:	INCIDENT REPORTED TO:	

BODY PART INJURED AND NATURE OF INJURY (e.g., puncture to right foot, strained left wrist, cut on right index finger, tick bite on left arm, burn, etc.):

INJURY SOURCE (e.g., wet pavement, jack hammer, keyboard, etc.):

HOW INJURY OCCURRED (struck by …, fell from …, exposed to …, etc.):

EMPLOYEE'S STATEMENT OF WHAT OCCURRED
(Include as much detail as possible such as activity being performed, objects carried, equipment used, hazardous conditions, etc.):

☐ In my opinion, I am not in need of any medical treatment at this time.

OR

In my opinion, I have received sufficient on-site first aid care in the form of:

☐ Application of antiseptics
☐ Application of bandage(s)
☐ Use of nonprescription medications
☐ Treatment of first-degree burn(s)
☐ Use of elastic bandage(s)
☐ Application of hot or cold compress(es)
☐ Removal of foreign bodies not embedded in eye (only irrigation required)
☐ Removal of foreign bodies from wound (uncomplicated procedure, for example, using tweezers)
☐ Application of ointments to abrasions to prevent drying or cracking

WHO WITNESSED THE INCIDENT?

☒ The above information is true and correct to the best of my knowledge.
☒ I understand that **I am not filing a Workers' Compensation claim** at this time. I do not choose to complete the DWC Form 1 "Employee's Claim for Workers' Compensation Benefits" at this time. If I am in need of medical treatment in the future related to this incident, I will immediately inform my Supervisor and complete a Claim Form Packet including the DWC Form 1.

EMPLOYEE'S PRINTED NAME AND SIGNATURE:	DATE:

SUPERVISOR COMPLETE THIS SECTION OF THE FORM

MEDICAL TREATMENT *(NOTE: If the Employee needs/requests medical treatment from a physician, complete the Claim Form Packet)*

☐ EMPLOYEE DECLINED MEDICAL TREATMENT
☐ EMPLOYEE RECEIVED MINOR FIRST AID ON-SITE AS NOTED ABOVE.

SUPERVISOR *(Print Name)*:	TITLE	DEPARTMENT HEAD (OR DELEGATE)	
SIGNATURE:	DATE	SIGNATURE	DATE
TELEPHONE:			

Initial Distribution: **Department Supervisor** *Initiate incident investigation in accordance with the Injury & Illness Prevention Program (IIPP)*
WCC: Risk Management

Revised 4/28/10

Revised 4/28/10

INSTRUCTIONS FOR COMPLETING SUPERVISOR'S INCIDENT REPORT

- The Supervisor's Incident Report 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." Reference: Section 14300.29 (b)(6)-(10). When a work connected fatality or hospitalization occurs, the State of California requires the employer to immediately (within 8 hours) contact CalOSHA Area Office (800-963-9424) to report the incident. Reference: General Industry Safety Orders Section 342 Reporting Work Connected Fatalities and Serious Injuries.

- The purpose of the Supervisor's Incident Report form is to get the specific facts; the who, what, why, where, when and how related to the incident and use the information to prevent future injuries in addition to meeting recordable injury reporting requirements.

- Within 7-days of receiving information that a work-related injury or illness has occurred, or a work-related injury where the employee declined medical treatment, this form must be completed. The sooner you complete the form, the more accurate your report will be.

- Investigate the injury or incident, then complete and submit the form even if the employee declines medical treatment.

- Unsafe Act – If you indicate there was no unsafe act, please explain why. Attach additional pages if necessary.

- If an unsafe act is checked, you must complete the preventive action(s) to be taken. If "other" is checked, you must describe what the preventive action(s) is. Attach additional pages if necessary.

- Unsafe Conditions – If you indicate there was no unsafe condition, please explain why. Attach additional pages if necessary.

- If an unsafe condition is checked, you must complete the preventive action(s) to be taken. If "other" is checked, you must describe what the preventive action is. Attach additional pages if necessary.

- Complete the Safety Training questions located below the Lost-time certification section. If left blank it will be returned for completion. "N/A," or "not applicable" is not acceptable. If you feel no post-incident safety training is necessary, then explain why. Attach additional pages as necessary.

- Distribution: Submit the completed form to Risk Management – Workers' Compensation after signing it via email (contact WC at 225-5141 for direction regarding which email(s) to use), or via fax to 530-225-5251. If you do not have email or fax access, send a copy inter-office mail to Risk Management at CH-202. The original should be forwarded via inter-office mail to Risk Management after the Department Head or the designee also signs the form. Check with your department for any departmental distribution policies.

Supervisor Complete

SHASTA COUNTY RISK MANAGEMENT

SUPERVISOR'S INCIDENT REPORT

EMPLOYEE NAME:	Gender: ☐M ☐F	☐FULL TIME ☐PART TIME
JOB TITLE:	DEPARTMENT:	WORK PHONE NO.

INVESTIGATION

Interview the Employee and investigate the reported incident and then complete the following:
Use the back of this form and additional sheets as necessary to obtain and record all pertinent information

☐ Check this box if a Declination of Medical Treatment Packet was previously completed for this same incident.

INCIDENT DATE:	TIME OF INCIDENT:	LOCATION OF INCIDENT (building location, department, etc.):
DATE REPORTED:	TIME BEGAN WORK:	

DESCRIPTION OF INCIDENT - Interview the Employee and any witnesses, and determine how the incident occurred and what the employee was doing prior to incident.

Has a similar incident occurred in the past? **Yes** ☐ NO ☐ **Have you contacted Fleet** ☐ **Facilities** ☐

DESCRIPTION OF THE INJURY- Body part injured, type of injury, etc.

INJURY SOURCE- Investigate and comment on the source of the injury. For example, if the employee has a laceration caused by a tool, examine the tool and indicate whether is appears to be in proper condition, is properly guarded, etc.

HOW INJURY OCCURRED - Investigate how the injury occurred, and determine whether it was caused by an unsafe act or an unsafe condition, or both. Use the sections below to detail the nature of the act(s) or condition(s) that may have caused or contributed to the incident.

UNSAFE ACT (IF ANY)		PREVENTIVE ACTION(S) TO BE TAKEN
☐ IMPROPER BODY POSITIONING	☐ UNSAFE WORK METHOD	☐ PROVIDE ADDITIONAL TRAINING
☐ HURRIED OR DISTRACTED WORK	☐ UNSAFE USE OF EQUIPMENT	☐ DISCIPLINE EMPLOYEE
☐ FAILURE TO USE PROPER PERSONAL PROTECTIVE EQUIPMENT (Specify):	☐ IMPROPER LIFTING TECHNIQUE	☐ MODIFY/DISCONTINUE WORK PRACTICE
	☐ OVEREXERTION	☐ OTHER:
☐ NO UNSAFE ACT	☐ OTHER:	

UNSAFE CONDITION (IF ANY)		PREVENTIVE ACTION(S) TO BE TAKEN
☐ DEFECTIVE EQUIPMENT	☐ IMPROPER LIGHTING	☐ ELIMINATE CONDITION
☐ UNGUARDED EQUIPMENT	☐ INADEQUATE VENTILATION	☐ REPAIR CONDITION
☐ TRIP/SLIP HAZARD ON FLOOR	☐ UNFORESEEN HAZARD/WEATHER	☐ REPORT CONDITION TO:
☐ UNSAFE ARRANGEMENT OF ITEMS	☐ OTHER:	☐ OTHER:
☐ IMPROPER DRESS OR APPAREL		
	☐ NO UNSAFE CONDITION	

LOST-TIME CERTIFICATION FROM SUPERVISOR

Did employee lose at least one day of work after injury? Yes ☐ NO ☐ Did employee receive full wages for last day worked? * Yes ☐ NO ☐

If "Yes" Last day worked: _____ Date claim form provided to employee _____

Has employee returned to work? Yes ☐ NO ☐ Name of clinic, physician, or hospital: _____

Date employee returned to work: _____ * Indicate if sick leave was used: Yes ☐ NO ☐

What safety training did the employee receive in the past 12 months that is specifically related to this incident?

What type of safety training will be necessary?

SUPERVISORY SIGNATURES

SUPERVISOR *(Print Name)*:	TITLE		DEPARTMENT HEAD (OR DELEGATE)
SIGNATURE:	DATE	SIGNATURE	DATE
TELEPHONE:			

WITNESS STATEMENT

If there was a witness to this incident, they should attach a detailed statement regarding their observation of the incident, and sign below.

WITNESS STATEMENT (use back of page if necessary):

NAME:	SIGNATURE:	DATE:

EMPLOYEE INSTRUCTIONS FOR COMPLETING DWC-1 FORM

If you have an illness or injury related to your job and you wish to file a workers' compensation claim and receive benefits, you may do so by completing the DWC-1 Form. There is no requirement that you do so, the choice is yours.

To file a claim for workers' compensation benefits, you need to do the following:

1. Report your illness or injury to your supervisor and explain that you wish to file a workers' compensation claim.

2. The supervisor will provide you with a workers' compensation claim packet. Sign the bottom of the instructions page and indicate if you went to the designated medical facility or to your predesignated physician. Your supervisor will date and initial Line 13 of the DWC-1 Form and ask you to sign the goldenrod copy, and will keep the goldenrod copy as an acknowledgment that you have been given the DWC-1 Form. When completing the DWC-1 Form, either type or press firmly, using a ballpoint pen on a hard surface.

3. Fill in all the blanks in the upper portion of the DWC-1 Form, and complete the following forms:

    a. "Authorization for Use or Disclosure of Protected Health Information" (4 pages)
    b. "Medical Mileage Expense Form", (goldenrod form) if applicable.

4. Return the completed DWC-1 Form and Authorization for Use or Disclosure of Protected Health Information" (4 pages) to your supervisor immediately if you wish to file a claim.

5. Be sure to tell the supervisor:

    a. Your name
    b. Date and time of illness/injury
    c. Description of your illness/injury
    d. If medical attention was sought prior to reporting illness/injury
    e. Who provided medical treatment
    f. Names of anyone who witnessed the incident

6. The Supervisor will give you the pink copy of the DWC-1 Form to take with you to Agile Redding or your personal physician (only if you have a personal physician card on file with Risk Management), when you seek medical treatment.

7. When receiving treatment, be sure to follow the doctor's instructions.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included 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 Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir 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 benficios 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 occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ 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 adminstradora 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.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

Rev. 1/1/2016 Signature/Firma _____ Date/Fecha _____

Claim Form Packet Instructions

An injury or illness has occurred. Follow all instructions to complete this packet prior to medical treatment. If the Supervisor takes the Employee to a medical facility, then the packet can be completed there. If there is an emergency call 911, and then complete the packet as soon as possible after treatment.

Employee:

- ☐ Complete the Employee portion of the ***DWC-1 Form "Employee's Claim for Workers' Compensation Benefits."***

Supervisor:

- ☐ Complete the Employer portion of the ***DWC-1 Form "Employee's Claim for Workers' Compensation Benefits."***
- ☐ Complete the ***Supervisor's Incident Report***.

Distribution of Forms:

- ☐ Employee: Keep ***the pink copy of DWC-1***.
- ☐ Supervisor: Send original DWC-1 and Supervisor's Incident Report to your Department Personnel Technician for completion of the OSHA 5020.
- ☐ Department Personnel Technician: forward all originals to Risk Management Immediately.

Employee: Sign here to acknowledge receipt of the Claim Form Packet

_____

EMPLOYEE'S SIGNATURE

Check to indicate treatment location:

☐ Designated Medical Facility ☐ Pre-designated Physician

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

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

OSHA CASE NO.

FATALITY ☐

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

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

EMPLOYER

1. FIRM NAME | 1a. Policy Number

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

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

4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc. | 5. State unemployment insurance acct.no

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

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy) | 8. TIME INJURY/ILLNESS OCCURRED _____AM _____PM | 9. TIME EMPLOYEE BEGAN WORK _____AM _____PM | 10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No | 12. DATE LAST WORKED (mm/dd/yy) | 13. DATE RETURNED TO WORK (mm/dd/yy) | 14. IF STILL OFF WORK, CHECK THIS BOX: ☐

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No | 16. SALARY BEING CONTINUED? ☐ Yes ☐ No | 17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy) | 18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)

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

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip) | 20a. COUNTY | 21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop. | 23. Other Workers injured or ill in this event? ☐ Yes ☐ No

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

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

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

27. Name and address of physician (number, street, city, zip) | 27a. Phone Number

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

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

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

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

EMPLOYEE

30. EMPLOYEE NAME | 31. SOCIAL SECURITY NUMBER | 32. DATE OF BIRTH (mm/dd/yy)

33. HOME ADDRESS (Number, Street, City,Zip) | 33a. PHONE NUMBER

34. SEX ☐ Male ☐ Female | 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers) | 36. DATE OF HIRE (mm/dd/yy)

37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours | 37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal | 37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED

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

Completed By (type or print) | Signature & Title | Date (mm/dd/yy)

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

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

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Shasta County

SUPPORT SERVICES - RISK MANAGEMENT

1450 Court Street, Room 348
Redding, CA 96001-1676
(530) 225-5141
(530) 225-5251 FAX
California Relay Service at 711 or 800 735-2922

Dear Injured Worker:

In order to comply with California Labor Code §5402, Employer's Notice to Employee regarding on-the-job injury/illness, we are enclosing the following for your assistance and information:

1. "Facts About Workers' Compensation" pamphlet.

2. "Medical Mileage Expense" form. Shasta County Risk Management will reimburse you for mileage to your treating physician and for therapy appointments.

3. "Authorization for Use or Disclosure of Protected Health Information" (4 page form). This release is necessary because a physician or chiropractor will not release medical reports necessary for determination of your claim without your written permission. Please sign and return to Risk Management when filing a claim.
Please complete and return to Risk Management when filing a claim.

Also, in order to comply with California Labor Code, Administrative Rules of the Division of Industrial Accidents, §9782, Shasta County Risk Management is given medical control for the first thirty (30) days from the date of an on-the-job injury/illness, unless the employee has notified Shasta County Risk Management, prior to the injury, that he/she has a pre-designated treating physician. Any medical treatment obtained from any source other than your pre-designated treating physician, (card on file at Risk Management Office prior to injury), or Shasta County's designated medical facility will be at the expense of the employee. The designated medical facilities are:

Agile Occupational Medicine
1710 Churn Creek Road
Redding, CA 96002
(530) 646-4242

Pulse Urgent Care Center
100 E. Cypress Avenue
Redding, CA 96002
(530) 722-1111

Burney Health Center
20641 Commerce Way
Burney, CA 96013
(530) 335-5457

HOSPITALS:

Shasta Regional Medical Center 1100 Butte Street Redding, CA 96001 (530) 244-5400	Mercy Medical Center 2175 Rosaline Avenue Redding, CA 96001 (530) 225-6000	Mayer's Memorial 43563 Highway 299 East Fall River Mills, CA 96028 (530) 336-5511

If you have any questions, please don't hesitate to contact our office at (530) 225-5141.

Sincerely,

Steve Taylor
Workers' Compensation Analyst III

Angelika King
Senior Workers' Compensation Adjuster

Jennifer Ferrell
Workers' Compensation Adjuster II

Enclosures

01/17/2023

SUPPORT SERVICES - RISK MANAGEMENT

1450 Court Street, Room 348
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(530) 225-5141
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MEMORANDUM

TO: All County Employees
FROM: Shasta County Risk Management
DATE: 10/03/2022
SUBJECT: HOSPITAL EMERGENCY ROOM USAGE FOR ON-THE-JOB INJURIES/ILLNESSES

This memo is a reminder that the emergency room is for EMERGENCIES ONLY. This also applies to any on-the-job injury/illness. Please use the emergency room only when your injury/illness is life threatening or when a delay in treatment would decrease the likelihood of maximum recovery. Examples of appropriate emergency treatment are: fractures, extensive blood loss, loss of consciousness, intolerable levels of pain, excessive swelling, or poisoning.

Examples of non-emergency treatment are: minor cuts not requiring sutures, splinters, minor burns (first degree), minor abrasions, bruises and sprains. Obviously, if the injured body part is extremely painful or swollen, you should seek emergency treatment. If not, you should go to Agile Occupational Medicine (Agile Redding) located at 1710 Churn Creek Road, behind Dairy Queen in Redding, Burney Health Center in the Burney/Fall River area, or your pre-designated treating physician if you have pre-designated one and the card is on file at Risk Management prior to the time of injury. Agile Redding is open with the following hours: Monday through Friday, from 8:00 a.m. to 6:00 p.m. and is closed on the following major holidays: New Year's Day, Presidents' Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas. Please, do not wait until your shift is over when Agile Redding is closed and then seek treatment in a hospital emergency room. Tetanus shots, if needed, can wait 48 hours from the time of injury.

If your injury is serious, go to Mercy Medical Center, Shasta Regional Medical Center in Redding, or Mayers Memorial in Fall River Mills emergency room for treatment. If the injury occurs after hours or on the weekend and can be treated with simple first-aid, do so, then see your pre-designated treating physician, Agile Redding, or Burney Health Center first thing in the morning or on Monday. Using the emergency room for first-aid treatment incurs unnecessary costs, can delay treatment to others who have a serious injury, and may not be paid by Risk Management unless it meets the criteria specified in paragraph one.

Remember, unless you have pre-designated a treating physician who has your records and has treated you in the past PRIOR to your injury/illness, and unless this card is on file with Risk Management, you must go to Agile Redding for treatment during the first thirty (30) days after the injury/illness. If you seek treatment elsewhere (except in the case of an emergency), you may be liable for the expenses incurred. Your help in complying with these standards will be appreciated.

AUTHORIZED PHARMACIES FOR ON THE JOB INJURY/ILLNESS PRESCRIPTIONS

NAME	ADDRESS	CITY	STATE	ZIP
COSTCO PHARMACY	1300 DANA DR	REDDING	CA	96003
COTTONWOOD DRUG	20635 GAS POINT RD	COTTONWOOD	CA	96022
FERRYS PHARMACY	2940 EAST ST	ANDERSON	CA	96007
LIMS FAMILY PHARMACY	1035 PLACER ST STE 110	REDDING	CA	96001
CVS DRUG STORE	3375 PLACER ST	REDDING	CA	96001
CVS DRUG STORE	1060 E CYPRESS AVE	REDDING	CA	96002
OMNICARE REDDING	5200 CHURN CREEK RD # A	REDDING	CA	96002
OWENS HEALTHCARE	1002 PLACER ST	REDDING	CA	96001
OWENS HEALTHCARE	317 LAKE BLVD # 8	REDDING	CA	96003
OWENS PHARMACY	2510 AIRPARK DR # 204	REDDING	CA	96001
OWENS PHARMACY	2025 COURT ST # A	REDDING	CA	96001
OWENS PHARMACY	2025 COURT ST # B	REDDING	CA	96001
OWENS PHARMACY	2920 CHURN CREEK RD	REDDING	CA	96002
OWENS PHARMACY	2995 EAST ST	ANDERSON	CA	96007
RALEY'S DRUG CENTER	201 LAKE BLVD	REDDING	CA	96003
RITE-AID PHARMACY	1801 EUREKA WAY	REDDING	CA	96001
RITE-AID PHARMACY	6424 WESTSIDE RD	REDDING	CA	96001
RITE-AID PHARMACY	975 E CYPRESS AVE	REDDING	CA	96003
RITE-AID PHARMACY	2641 BALLS FERRY RD	ANDERSON	CA	96007
RITE-AID PHARMACY	5350 SHASTA DAM BLVD	SHASTA LAKE	CA	96019
RITE-AID PHARMACY	37435 MAIN ST	BURNEY	CA	96013
SAFEWAY PHARMACY	2275 PINE ST	REDDING	CA	96001
SAFEWAY PHARMACY	1070 E CYPRESS AVE	REDDING	CA	96002
SAFEWAY PHARMACY	2601 BALLS FERRY RD	ANDERSON	CA	96007
SAFEWAY PHARMACY	1630 MAIN ST	BURNEY	CA	96013
SHOPKO PHARMACY	55 LAKE BLVD	REDDING	CA	96003
TARGET PHARMACY	1280 DANA DR	REDDING	CA	96003
WALGREENS	980 E CYPRESS AVE	REDDING	CA	96002
WALGREENS	1205 COURT ST	REDDING	CA	96001
WALGREENS	115 LAKE BLVD E	REDDING	CA	96003
WALMART PHARMACY	1515 DANA DR	REDDING	CA	96002
WALMART PHARMACY	5000 RHONDA RD	ANDERSON	CA	96007
RITE AID PHARMACY	9390 DESCHUTES RD	PALO CEDRO	CA	96073
OWENS PHARMACY	9387 DESCHUTES RD 1	PALO CEDRO	CA	96073

Shasta County Risk Management
1450 Court Street, Room 348
Redding, CA 96001
Phone: (530) 225-5141
Fax: (530) 225-5251

Authorization for Use or Disclosure of Protected Health Information (PHI)

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

I authorize: Please see attached
(Name of Person and/or Facility which has information)

_____
(Street Address, City, State, Zip Code)

To release health information to:

Legal Photocopy Service representing Shasta County Risk Management and/or attorney of record
(Specify Name/Title of Person and/or Facility to receive health information)

2700 Eureka Way, Redding, CA 96001
(Street Address, City, State, Zip Code)

Please specify the health information you authorize to be released:

☐ **Medical Records** ☐ **Mental Health (other than Psychotherapy notes)**

Type(s) of health information: Any and all medical records

Date(s) of treatment: Any and all dates of service

Revision 12/27/16

The following information will not be released unless you specifically authorize it by marking the relevant box(s) below:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- ☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)
- ☐ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)

The purpose of this release is for (check one or more):

(State reason): ☐ Legal Review and/or ☐ a claim filed and/or ☐ a lawsuit filed

NOTICE

Many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to:

Shasta County Risk Management, 1450 Court St., Room 348, Redding CA 96001
Department Name and Mailing Address

This revocation will take effect when addressee receives it, except to the extent addressee or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this Authorization expires _____(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____

Print Name Signature (Patient, Parent, Guardian)

_____ _____

Date Relationship to Patient

AUTHORIZATION TO RELEASE INFORMATION

PATIENT'S NAME: _____ SSN: _____

AKA: _____

To the Employee: Please list the name and addresses of **any and all** doctors, hospitals, and chiropractors you have seen. This should include the name of your family doctor, any visits made to hospitals and clinics **(even emergency room visits)** and the names of any other physicians or chiropractors you have seen. Please be certain to indicate if any treatment was received under another name, such and a maiden name**. Please list the above whether or not it is related to this injury.**

YOUR FAMILY DOCTOR:

_____

_____

_____

HOSPITALS AND CLINICS:

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

_____

_____

ANY OTHER PHYSICIANS:

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

CHIROPRACTORS:

1. _____

_____

_____

2. _____

_____

In addition to the records of the physicians you have identified and released above, you are required to notify us of any and all physicians with whom you have treated by whose records you decline to release with this authorization.

_____ _____

Injured Worker's Name Claim Number

PURPOSE

To provide full wage or salary compensation for an employee who is absent from work as a result of an industrially related illness or injury where Section 4652 of the Labor Code is applicable. (This policy is also in the Personnel Rules as Section 13.3.)

POLICY

For an employee to receive industrial leave, he or she must apply for workers' compensation benefits and supply supportive medical evidence that there was an industrial injury or disease contracted in the course and scope of employment, which prevents the employee from performing his or her duties.

Such compensation shall be applied to wage loss for the date of injury and subsequent workdays lost during the thirty (30) days immediately following the date of injury. In no event shall compensation exceed 32 hours.

On the fourth consecutive calendar day following the date of injury or illness, provided the employee remains off work, temporary disability benefits will then be paid in accordance with Labor Code §4653.

Beginning with the date temporary disability benefits are applicable (Labor Code §4653) and every day of covered absence thereafter, in the following order, an employee's compensatory time off, sick leave, administrative leave, and vacation may be charged to assure that, when added to temporary disability benefits paid under workers' compensation, the employee will receive as near to but not exceeding his or her full salary or wage. The employee, at his or her option, may elect any order of application of compensatory time, sick leave, administrative leave, vacation, or none of the preceding benefits if he or she notifies Risk Management in writing within 14 days of the date of injury.

RESPONSIBLE DEPARTMENTS

Support Services -- Risk Management Auditor-Controller

REFERENCES

Administrative Update--07/13/2012
Board Policy Resolution No. 2001-10--8/14/01 (Amended) Board Policy Resolution No. 95-4--3/14/95 (Amended)
Board Policy Resolution No. 92-4--8/18/92
Personnel Manual Section 1172 (repealed)
California Labor Code Section 4653

SHASTA COUNTY RISK MANAGEMENT

WORK ACCOMODATION GUIDE

EMPLOYEE KEEP FOR REFERENCE

After each medical appointment:

- Provide any work restrictions given by the physician to your Supervisor.

- Your work status will be determined and you will be advised to take one of the following sets of actions:

A. <u>If you are released to Usual & Customary position (full duty):</u>

Your Supervisor will advise you to return to work.

B. <u>If you have any work restrictions:</u>

Your Supervisor will engage you in an interactive process to determine if an appropriate Transitional Assignment/Light Duty is available. If an assignment is available, you will review the ***Work Accommodation Meeting*** form.

C. <u>If you are Totally Temporarily Disabled:</u>

If you are unable to return to any assignment, you may be contacted regarding your work status.

D. <u>If you are Permanently Disabled:</u>

If you become permanently unable to return to the Usual & Customary position, the Department will initiate an interactive process with you to identify a Modified or Alternative placement within the County as available.

- Continue treatment with your Treating Physician and, after each appointment, provide Work Restrictions to your Supervisor. If at any time you wish to change treating physicians, you must <u>notify Risk Management immediately</u>.

Initial Distribution: Employee
Employee: Retain for reference

SHASTA COUNTY RISK MANAGEMENT

FMLA LEAVE NOTIFICATION

EMPLOYEE - KEEP
FOR REFERENCE

TO: Employee

FROM: Risk Management

This memo has been included in the Claim Form Packet in case you become Totally Temporarily Disabled from Usual and Customary work as a result of an injury/illness that may be work-related.

If you do become Totally Temporarily Disabled from Usual and Customary work, and if you are eligible for leave under the Family & Medical Leave Act (FMLA), then all leaves of absence related to the injury/illness will be considered part of the 12-week period of job protection designated by the FMLA.

If you would like more information about the FMLA and/or your eligibility, please contact your Supervisor.

Shasta County

PATIENT NAME: _____

Activity	Never 0 Hours	Occasionally Up to 3 hours	Frequently 3-6 hours	Constantly 6-8 hrs +
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck)				
Twisting (waist)				
Ability to drive a vehicle				
Ability to dress w/o assistance				
Hand use / dominant hand: Right or Left (please circle)				
Simple Grasping				
Power Grasping				
Fine Manipulation				
Pushing / Pulling				
Reaching **ABOVE** shoulder level				
Reaching **BELOW** shoulder level				

LIFTING	Never 0 hours	Occasionally Up to 3 hrs	Frequently 3 – 6 hrs	Constantly 6-8+ hrs	Height
0-10 lbs					
11-25 lbs					
26-50 lbs					
51-75 lbs					
76-100 lbs					
100+ lbs					

CARRYING	Never 0 hours	Occasionally Up to 3 hrs	Frequently 3 – 6 hrs	Constantly 6-8+ hrs	Distance
0-10 lbs					
11-25 lbs					
26-50 lbs					
51-75 lbs					
76-100 lbs					
100+ lbs					

Physician's signature _____ Date _____

PLEASE RETURN BY FAX TO RISK MANAGEMENT (530) 225-5251

Injured worker's name/
Nombre de la lesionada

Claim number/numero de reclamo

Medical Mileage Expense Form
Forma De Gastos Por Distancia Recorrida Por Visitas Medica

If you have to travel to get treatment for your work injury, you are entitled to re-payment of your travel costs. The mileage rate is ** cents per mile. Mileage for reasonable travel to the pharmacy, parking, bridge tolls, public transportation and other travel-related costs are also included. Complete this form. Attach receipts. Send the original to Shasta County Risk Management, and keep a copy.

Si tiene que viajar para recibir tratamiento por una lesion en el trabajo, usted tiene derecho a recibir un reembolso de ** centavos por milla. Millas por un viaje de distancia razonable a la farmacia, estacionamiento, pago de peaje, transporte publico y otros viajes y costos relacionados estan tambien incluidos. Complete esta forma y adjunte los recibos. Envie la forma original a la Shasta County Risk Management y guarde una copia

Date/Fecha	**Travel from** (include address) **Viaje Desde** (incluya direccion)	**Travel to** (include name and address of doctor, hospital, therapist, etc.) **Viaje a** (incluya nombre y direccion)	**Round trip mileage/ Millaje viage redondo**	**Parking/ Estacion-amiento**	**Tolls/ Peaje**

California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for a payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Las Leyes de California establecen que la siquiente declaracionparezca en esta formulario: Cualqier persona que a sabiendas presente reclamos falsos o fradulentos para el pago de una perdida, sera culpable de un delito y se le podria multar y encarcelar en la penitenciaria estatal

Total Miles		X .67 Miles =	$
		Total Parking =	$
		Total Tolls =	$
		Total Reimbursement Requested	$

Signature/Firma

Printed Name/Imprima su nombre

Date/Fecha

**Note: from 01/01/19 to 12/31/19, mileage paid at $.58
from 01/01/20 to 12/31/20, mileage paid at $.575
from 01/01/21 to 12/31/21, mileage paid at $.56
from 01/01/22 to 06/30/22 mileage paid at $.585
from 07/01/22 to 12/31/22 mileage paid at $.625
from 01/01/23 to 12/31/23, mileage paid at $.655
from 01/01/24 onward, mileage paid at $.67

Revised 1/1/2024