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EMPLOYER INJURY CHECKLIST

Employee Name: _____
Date of Incident: _____
Date Reported: _____
Treatment Requested: ☐ **Yes** ☐ **No**

EMERGENCY IMMEDIATELY CALL: 911
SERIOUS INJURIES ARE TO BE REPORTED TO OSHA WITHIN 8 HOURS

1. REPORT THE INJURY

☐ Call and report the incident with the employee to Company Nurse at (888) 375-0280
- Company Nurse will refer the employee to a clinic

2. PROVIDE EMPLOYEE WITH:

☐ DWC-1 (Employee Claim Form) **within ONE working day of knowledge of injury**, ONLY if seeking treatment
- Send DWC-1 to employee via first class mail within 24 hours of injury if not able to do so in person
- Fill out bottom half of form. Employee to fill out top half of form
- When DWC -1 is returned complete #14 [date Returned]
- Provide copy of the completed DWC-1, to the employee. Retain a copy for your records

☐ Medical Provider Network Pamphlet (English or Spanish)
☐ Temporary Prescription Form (English or Spanish)
☐ Information for Injured Workers (CSRM WC 103)
☐ Employee Satisfaction Survey (CSRM WC 104)
☐ Workers' Compensation Acknowledgement Form (CSRM WC 105)

3. HAVE EMPLOYEE COMPLETE

☐ ***Employee Report of Incident (CSRM WC 101)***
a. Retain a copy for your records

4. SUPERVISOR IS TO:

☐ **Complete *Supervisor's Incident Investigation Report (CSRM WC 102)***
a. Send original to your Workers' Compensation Coordinator
b. Retain copy for your records

☐ **Investigate the accident and address any problems**
- **DO NOT discard equipment or furnishings that caused injury**
- Correct any immediate hazards to prevent further injuries
- Remove the equipment from service
- Tag the equipment for identification and take photos, if possible
- If caused by third-party, obtain contact information and insurance information, if applicable

☐ **Have Witnesses complete statements**
a. Send original to Workers' Compensation Coordinator
b. Retain copy for your records

5. Employer's Workers' Compensation coordinator to:

☐ Complete the Employer's Report of Occupational Injury or Illness (Form 5020) **within FIVE working days** and send to the claims administrator

IF THE EMPLOYEE IS NOT SEEKING TREATMENT:

1. **Call and report the incident with the employee to Company Nurse (888) 375-0280**
2. **DO NOT provide the employee with a DWC-1 (Employee Claim Form)**
3. **Complete the *Declination of Treatment Packet***
4. **If, later, the employee requests treatment related to this incident, complete steps 1-4 above within ONE working day**

(Rev. 07/01/2022)

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.

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

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la 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.

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.* _____
Sedgwick P.O. Box 619179, Roseville, CA 95661
16. Insurance Policy Number. *El número de la póliza de Seguro.* California Schools JPA, Permissably Self-Insured
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*

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, l 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 arriesg 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 estales. 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- SJDB)*: 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 un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, 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 Estatalde 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.

Complete Written Employee Notification
WellComp MPN
MPN Identification Number: 2387

Access to Medical Care

This notice contains important information on accessing the WellComp MPN (referred herein as "WellComp"

- Find out if you are covered
- Access medical care
- Learn about continuity of care
- Choose your own physician
- Transfer into the WellComp network ✓ Contact WellComp

Welcome to WellComp
Your employer has selected WellComp as your medical provider network (MPN), to provide you with the choice of a broad scope of medical services for work-related injuries and illnesses.

WellComp's exclusive network of healthcare providers each have a thorough understanding of the California workers' compensation system and its potential impact on you. The state of California has approved the WellComp MPN to cover your workers' compensation medical care needs. If you suffer an injury or illness on or after your employer's MPN implementation date and you have not predesignated a personal physician, you are automatically covered by the WellComp MPN.

Initial Care
In case of an emergency, you should call 911 or go to the closest emergency room.
If you experience a work-related injury or illness, immediately notify your supervisor and obtain medical authorization from your employer to designate an initial care provider within the network. If you are unable to reach your supervisor or employer, please contact the patient services department at WellComp. For non-emergency services, the MPN must ensure that you are provided an appointment for initial treatment within 3 business days of your employer's or MPN receipt of request for treatment within the MPN.

Subsequent Care
If you still need treatment following your initial evaluation, you may be treated by a physician of your choice, or the initial physician may refer you to a medically and geographically appropriate specialist within the network who can provide the appropriate treatment for your injury or condition. Your employer is required to provide you with at least three physicians of each specialty expected to treat common injuries experienced by injured employees based on your occupation or industry. These physicians will be available within 30 minutes or 15 miles of your workplace or residence and specialists will be available within 60 minutes or 30 miles of your residence or workplace. For a directory of providers, please visit www.WellComp.com or call WellComp Patient Services.

Emergency Care
In an emergency, defined as a medical condition starting with the sudden onset of severe symptoms that without immediate medical attention could place your health in serious jeopardy, go to the nearest healthcare provider regardless of whether they are a WellComp participant. If your injury is work-related, advise your emergency care provider to contact WellComp to arrange for a transfer of your care to a WellComp provider at the medically appropriate time.

Hospital and Specialty Care
Your primary treating physician in the WellComp network can make all of the necessary arrangements and referrals for specialists, inpatient hospital, outpatient surgery center services, and ancillary care services.

Choosing a Treating Physician
If you still require treatment after your initial evaluation with your employer's designated provider, you may access the WellComp Directory and select an appropriate physician of your choice who can provide the necessary treatment for your condition or illness. For assistance determining physician options, please contact the Medical Access Assistant in the WellComp Patient Services Department or discuss your options with your initial care provider.

Physicians who provide only tele-health services will not be counted when determining if an MPN has met access standards, if the injured covered employee does not consent to see the tele-health physician. The physician, who provides only tele-health services or also provides services at a physical location and tele-health, will be counted when determining if an MPN has met access standards, if the injured covered employee consents to see the tele-health physician. The physician, who provides only tele-health services or also provides services at a physical location and tele-health, will not be counted when determining if an MPN has met access standards, if the injured covered employee retracts consent to received tele-health services prior to delivery of tele-health treatment. The physician who provides both physical location and tele-health services will be counted under the access standards if the physician's physical location is within the required access standards in accordance with 8 CCR 9767.5(a)(1) and (a)(2).

Scheduling Appointments
If you are having difficulty scheduling an appointment with your initial provider or subsequent provider, please contact the Medical Access Assistant in the WellComp Patient Services Department or your Claims Examiner.

Changing Primary Treating Physician
If you find it necessary to change your treating physician and it is determined that you require ongoing medical care for your injury or illness, you may select a new physician from the WellComp Directory and schedule an appointment. Once your appointment is scheduled, immediately contact WellComp Patient Services who will then coordinate the transfer of your medical records to your new provider.

Obtaining a Specialist Referral
If you continue to require medical treatment for your injury or illness, there are alternatives for obtaining a referral to a specialist:

- Your primary treating physician in the WellComp network can make all of the necessary arrangements for referrals to a specialist. This referral will be made within the network or outside of the network if needed.
- You may select an appropriate specialist by accessing the WellComp Directory.
- You may contact your Medical Access Assistants in the WellComp Patient Services who can help coordinate necessary arrangements.

If your primary treating physician makes a referral to a type of specialist not included in the network, you may select a specialist from outside the network.

For non-emergency specialist services, the MPN must ensure that you are provided an appointment within 20 business days of your employer's or MPN receipt of a referral to a specialist within the MPN.

Continuity of Care
What if I am being treated by a WellComp doctor and the doctor leaves WellComp?
Your employer has a written "Continuity of Care" Policy that may allow you to continue treatment with your doctor if your doctor is no longer actively participating in WellComp.
If you are being treated for a work-related injury in the WellComp network and your doctor no longer has a contract with WellComp, your doctor may be allowed to continue to treat you if your injury or illness meets one of the following conditions:

- (Acute) A medical condition that includes a sudden onset of symptoms that require prompt care and has a duration of less than 90 days.
- (Serious or Chronic) Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- (Terminal) You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- (Pending Surgery) You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN contract termination date.

If any of the above conditions exist, WellComp may require your doctor to agree in writing to the same terms he or she agreed to when he or she was a provider in the WellComp network. If the doctor does not, he or she may not be able to continue to treat you.

If the contract with your doctor was terminated or not renewed by WellComp for reasons relating to medical disciplinary cause or reason, fraud or criminal activity, you will not be allowed to complete treatment with that doctor. For a complete copy of the Continuity of Care policy in English or Spanish, please visit www.WellComp.com or call WellComp Patient Services.

Transfer of Ongoing Care

What if you are already being treated for a work-related injury before the WellComp network begins?

Your employer has a "Transfer of Care" policy which describes what will happen if you are currently treating for a work-related injury with a physician who is not a member of the WellComp network. If your current treating doctor is a member of WellComp, then you may continue to treat with this doctor and your treatment will be under WellComp. If your current treating physician is not a participating physician within WellComp and you have not yet been transferred into the MPN, your physician can make referrals to providers within or outside the MPN. Your current doctor may be allowed to become a member of WellComp.

You will not be transferred to a doctor in WellComp if your injury or illness meets any of the following conditions:

- (Acute) The treatment for your injury or illness will be completed in less than 90 days.
- (Serious or Chronic) Your injury or illness is one that is serious and continues without full cure or worsens over 90 days. You may be allowed to be treated by your current treating doctor for up to one year from the date of receipt of the notification that you have a serious chronic condition.
- (Terminal) You have an incurable illness or irreversible condition that is likely to cause death within one year or less. Treatment will be provided for the duration of the terminal illness.
- (Pending Surgery) You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date.
- For a complete copy of the Transfer of Care policy in English or Spanish, please visit www.WellComp.com or call WellComp Patient Services.

Care Transfer Disputes

Notice of determination, from the employer or claims examiner, shall be sent to the covered employee's address and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible. If WellComp is going to transfer your care and you disagree, you may ask your treating doctor for a report that addresses whether you are in one of the categories listed above. Your treating physician shall provide a report to you within twenty calendar days of the request. If the treating physician fails to issue the report, then you will be required to select a new provider from within the MPN. If either WellComp or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. You must notify WellComp Patient Services Department if you disagree with this report.

If your treating doctor agrees that your condition does not meet one of those listed above, the transfer of care will go forward while you continue to disagree with the decision. If your treating doctor believes that your condition does meet one of those listed above, you may continue to treat with him or her until the dispute is resolved.

Second Opinion, Third Opinion and MPN Independent Medical Review Process:
If you disagree with your doctor or do not like your doctor for any reason, you may always choose another doctor in the MPN.

Obtaining Second and Third Opinions
If you disagree with the diagnosis or treatment plan determined by your treating physician or your second opinion physician, and would like a second or third opinion, you must take the following steps:

- Notify your claims examiner who will provide you with a regional area listing of physicians and/or specialists within the WellComp network who have the recognized expertise to evaluate or treat your injury or condition.
- Select a physician or specialist from the list Within 60 days of receiving the list, schedule an appointment with your selected physician or specialist from the list provided by your claims examiner. Should you fail to schedule an appointment within 60 days, your right to seek another opinion will be waived.
- Inform your claims examiner of your selection and the appointment date so that we can ensure your medical records can be forwarded in advance of your appointment date. You may also request a copy of your medical records.
- You will be provided information and a request form regarding the MPN Independent Medical Review (MPN IMR) process at the time you select a third opinion physician.
- If the Second/Third opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer. You will get another list of MPN doctors or specialists so you can make another selection.

If the 2nd/3rd opinion doctor agrees with your need for a treatment or test, you may be allowed to receive that recommended treatment or test from a provider inside or outside the MPN, including the 2nd or 3rd opinion physician.

Obtaining an MPN Independent Medical Review (MPN IMR)
If you disagree with the diagnosis or treatment plan determined by the third opinion physician, you may file the completed MPN Independent Medical Review Application form with the Administrative Director of the Division of Workers' Compensation. You may contact your claims examiner or the WellComp Patient Services Department for information about the MPN Independent Medical Review process and the form to request an MPN Independent Medical Review.

If the second opinion, third opinion or MPN IMR agrees with your treating doctor, you will need to continue to receive medical treatment with a network physician if the MPN contains a physician who can provide the recommended treatment. If the MPN IMR does not agree with your treating network physician, you will be allowed to receive that medical treatment from a provider either inside or outside of the WellComp network. Any physician chosen outside of the WellComp network must be within reasonable geographic area. The treatment or diagnostic test is limited to the recommendation of the MPN IMR.

Treatment Outside of the Geographic Area
WellComp has providers throughout California. If a situation arises which takes you out of the coverage area, such as temporary work, travel for work, or living temporarily or permanently outside the MPN geographic service area, please contact the WellComp Patient Services Department, your claims examiner, or your primary treating physician, and they will provide you with a selection of at least 3 approved out-of-network providers from whom you can obtain treatment or get second and third opinions from the referred selection of physicians.

Covered Medical Services:
The following is a summary of Workers' Compensation medical services available to employees covered by the WellComp network.

Primary treating and specialty services including consultations and referrals
Examples include general medical practitioners, chiropractors, dentists, orthopedists, surgeons, psychologists, internists, psychiatrists, cardiologists, neurologists.

Inpatient Hospital and Outpatient Surgery Center services
Examples include acute hospital services, general nursing care, operating room and related facilities, intensive care unit and services, diagnostic lab or x-ray services, necessary therapies.

Ancillary Care services
Examples include diagnostic lab or x-ray services, physical medicine, occupational therapy, medical and surgical equipment, counseling, nursing, medically appropriate home care, medication.

Emergency services Including Outpatient and Out of Area Emergency Care
Examples include outpatient and out-of-area emergency care.

WellComp Provider Directory
For more information about the MPN including access to a roster of all treating physicians and a roster of all participating providers in the MPN, go to www.WellComp.com where you can search by medical specialty, zip code, physician or provider group. For website assistance or to access a hard copy of the regional area listing and/or an electronic copy of the complete WellComp directory, please contact WellComp (your employer's designated medical provider network administrator.

Tele-Health Option
WellComp MPN has also made available providers who provide tele-health services. This service is optional and visible on our website designated by TH in the search results or using the Tele-Health search option. You may also call the network for assistance in finding a tele-health provider/and or facilitating an appointment. Our complete Tele-Health policy is visible on our website downloads.

Prior to delivery of health care via tele-health, the health care provider initiating the use of tele-health shall obtain verbal or written consent from the patient (Injured Covered Employee) for the use of tele-health as an acceptable mode of delivering health care services and public health. The consent shall be documented. (Pursuant to Business and Professions Code section 2290.5b)

WellComp Information

If you have questions or complaints about WellComp MPN, you may reach the MPN contact or WellComp Patient Services toll-free at (800) 544-8150. WellComp has individuals available to answer questions, provide website assistance, and generate provider listings. Medical Access Assistants (MAAs) are available to assist with finding an MPN physician of your choice, including scheduling and confirming

physician appointments. MAA's are available 7am to 8pm Pacific Standard Time, Monday through Saturday at the contact information below:

CareWorks Managed Care Services
8855 Haven Avenue
Rancho Cucamonga, CA 9173
Toll Free (800) 544-8150
Fax: (888) 620-6921
Email: info@WellComp.com

Occupational Injury Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su Primera visita, porfavor usar este documento en cualquiera de la farmacias listadas, al reverso de este documento. Esto acelerara el procesamiento de sus recetas relacionadas con su caso aprobado de lesion en el trabajo.

¿Tiene preguntas o necesita ayuda para localizar una farmacia de la red participante? Llame al Centro de contacto de atención al paciente myMatrixx al numero 800.945.5951.

sedgwick

Name: _____

ID#: **Present at Pharmacy

Date of Injury: _____

Group #: GJC7910

Employee Date of Birth: _____

WARN ME: OPIOIDS

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Pharmacist:

myMatrixx administers this occupational injury prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $1500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

Participating Retail Network Pharmacies

myMatrixx®
An Express Scripts Company

A & P	Drug Emporium	Longs Drug Store	Schnucks
Acme Pharmacy	Drug Fair	Major Value	Scolari's
Albertson's	Drug Town	Marsh Drugs	Sedano
Albertson's/Acme	Drug World	Medic Discount	Shaw's
Albertson's/Osco	Eckerd	Medicap	Shop 'N Save
Albertson's/Sav-On	Econofoods	Medistat	Shopko
Amerisource Bergen	EPIC Pharmacy	Meijer	ShopRite
Anchor Pharmacies	Network	Minyard	Snyder
Arrow	FamilyMeds	NCS HealthCare	Stop & Shop
Aurora	Farm Fresh	Neighborcare	Sun Mart
Bartell Drugs	Farmer Jack	Network Pharmaceuticals	Super Fresh
Bigg's	Food City	Northeast Pharmacy Services	Super Rx
Bi-Lo	Food Lion	Osco	Target
Bi-Mart	Fred's	P & C Food Markets	Texas Oncology Srvs
BJ's Wholesale Club	Gemmel	Pamida	The Pharm
Brooks	Giant	Park Nicollet	Thrifty White
Brookshire Brothers	Giant Eagle	Pathmark	Times
Brookshire Grocery	Giant Foods	Pavilions	Tom Thumb
Bruno	Hannaford	Price Chopper	Tops
Carrs	Harris Teeter	Publix	Ukrop's
Cash Wise	H-E-B	Quality Markets	United Drugs
Coborn's	Hi-School Pharmacy	Raley's	United Supermarkets
Costco	Hy-Vee	Randalls	Vons
Cub	Jewel/Osco	Rite Aid	Waldbaums
CVS	Kash n Karry	Rosauers	Walgreens
D&W	Keltsch	Rx Express	Wal-Mart
Dahl's	Kerr	RXD	Wegmans
Dierbergs	Kmart	Safeway	Weis
Discount Drugmart	Knight Drugs	Sam's Club	Winn Dixie
Doc's Drugs	Kroger	Sav-On	
Dominicks	LeaderNet (PSAO)	Save Mart	

INFORMATION FOR INJURED WORKERS

WHAT IS WORKERS' COMPENSATION?

Workers' compensation is a no-fault system designed to provide employees who sustain an injury or illness on the job with benefits to medically cure or relieve them of their industrial injury.

Benefits include: medical treatment, temporary disability benefits, permanent disability benefits, return to work benefits, and in the case of a death, benefits to qualified dependents.

WHEN AM I COVERED?

Coverage under workers' compensation begins when you arrive at work. If you are injured or sustain an illness that arose in the course and scope of employment your injury is covered.

Injuries or illnesses caused by a voluntary activity or off duty social or athletic activities may not be covered.

HOW DO I GET BENEFITS?

IMMEDIATELY notify your supervisor if you sustain a work-related injury or illness and report it to **Company Nurse at (888) 375-0280** to get the medical treatment you need without delay.

Benefits do not start until you notify your employer. Failure to timely report your injury may result in benefits being delayed and possibly denied.

If your injury or illness is more than first-aid, your supervisor will provide you with a Workers' Compensation Claim Form (DWC- 1). **To submit a claim**, complete the "Employee" section of the DWC-1 and mark the "Temporary Receipt" box, keep a copy and return the form to your supervisor to complete the "Employer" section. After the form is completed your supervisor will provide you with a completed copy and send a copy to the Workers' Compensation claims administrator.

California law requires medical treatment to be authorized within one working day of receipt of your DWC-1. If your claim is delayed for any reason, a determination must be made **within 90 days** of you filing your claim. During the delay period you will be **entitled to medical treatment up to $10,000**.

BENEFITS OVERVIEW:

There are five basic benefits provided through Workers' Compensation: medical treatment, temporary disability benefits, permanent disability benefits, supplemental job displacement benefits and in the case of an employee's death, death benefits.

EMERGENCY MEDICAL CARE:

If you are injured and need emergency medical care, go to the nearest emergency room or **CALL 911 IMMEDIATELY** and report your injury to your employer as soon as possible.

MEDICAL TREATMENT:

Workers' Compensation provides treatment that is reasonably necessary to cure or relieve the effects of the industrial injury or illness at no cost to you. Any mileage incurred related to medical treatment will be reimbursed at the Federal mileage rate, at the time it was incurred, so please make sure to record your mileage and submit it to the claims administrator.

California law prohibits an injured worker from being billed for treatment related to a claimed workers' compensation injury or illness. If you receive a bill from a medical provider regarding your claim **notify your Workers' Compensation claims adjuster.**

INFORMATION FOR INJURED WORKERS

MEDICAL PROVIDER NETWORK PROGRAM:

Medical treatment for a work-related injury or illness will be provided through your employer's **Medical Provider Network (MPN).** If you have an admitted injury or illness or while your claim of injury or illness is in a delayed status, you are required to treat within the **MPN** regardless of union representation, unless your personal care physician was pre-designated prior to your injury.

Once you report your injury you will be referred for medical treatment within the **MPN**. After your first visit you are free to change to any other physician within the **MPN**. If you wish to change your physician or location, contact and advise your claims adjuster.

THE RIGHT TO PRE-DESIGNATE YOUR PERSONAL TREATING PHYSICIAN:

You have the right to pre-designate your personal treating physician to treat you in the event of an industrial injury or illness. For the physician to be valid pre-designated physician, the physician must have been designated prior to your industrial injury or illness, you and your physician must have completed the requisite pre-designation form.

PHARMACY CARD:

When you file your claim, you will be provided with a temporary prescription ID card followed by a permanent card. Use this card to fill your authorized workers' compensation prescriptions at participating chain pharmacies at no cost to you.

UTILIZATION REVIEW:

When your primary treating physician makes a recommendation for treatment he or she must submit a request for authorization (RFA) for utilization review to determine whether the treatment being requested is appropriate.

UTILIZATION REVIEW TIMEFRAMES: Within **5 working days** of receiving an RFA, a notice of authorization, modification, denial or delay will be issued. If the RFA is delayed, a final determination will be issued no more than **14 calendar days** from the receipt of the initial request.

If there is any dispute over the utilization review determination, **at no cost to you**, you may appeal the decision either by asking your physician to schedule a peer-to-peer discussion with the Medical Director (physician who issued the determination) or **you must request an Independent Medical Review within 30 days of receiving the determination.**

BE A PROACTIVE PARTICIPANT IN YOUR RECOVERY. If your physician advises you of a treatment recommendation notify your claims adjuster so he or she may contact the physician for the treatment request, as the request may not always immediately be sent to the claims adjuster.

INDEPENDENT MEDICAL REVIEWER (IMR):

The State of California implemented an Independent Medical Reviewer (IMR) as a way for employees to appeal any determinations made by utilization review. **If you dispute the utilization review determination, you must request an IMR within 30 days of the decision**.

RETURN TO WORK TEMPORARY MODIFIED DUTY:

If your primary treating physician provides you with work restrictions, your employer may offer you a temporary modified or alternate position while you are in the recovery process. **Please note, if you are offered a temporary modified or alternate position and you choose to decline you may NOT be entitled to temporary disability benefits and or salary continuation.**

INFORMATION FOR INJURED WORKERS

TEMPORARY DISABILITY BENEFITS:

This benefit is tax free and based on two-thirds of your average weekly earnings with minimum and maximum rates set by the state of California and based on your date of injury and is paid out every two weeks.

If you are entitled to salary continuation under the Education Code, this benefit will be included in your regular check while you are receiving salary continuation.

While receiving temporary disability or salary continuation you are REQUIRED to report any earnings or income from any source to my claims adjuster as it may affect my entitlement to benefits. Failure to disclose this information may result in prosecution for violation of the Workers' Compensation Fraud law, and, if convicted, may result in a felony.

TO BE ELIGIBLE FOR TEMPORARY DISABILITY BENEFITS:

- ✓ Your claim must be accepted
- ✓ Your disability must be certified by the physician treating you for your workers' compensation claim AND the physician must be in the MPN or a valid pre-designated physician.
- ✓ You must be declared temporarily totally disabled or provided with work restrictions that cannot be accommodated by your employer

If you are provided with an offer of temporary modified duty and you chose not to accept, you may not be eligible for Salary Continuation and or Temporary Disability benefits.

For injuries on or after 04/19/2004, Temporary Disability benefits are limited to 104 weeks, and may be extended up to 240 weeks for serious injuries, in certain circumstances. These benefits normally continue until you return to work or are released from care.

SALARY CONTINUATION: Under the Education Code regular employees are entitled special benefits in the form of salary continuation.

Certificated:

- **60 Days -** 60 days of full salary per injury starts day one. The District makes up the difference between temporary disability income and the employee's regular pay.
- **Sick-Leave (pro-rated on an hourly and daily basis) -** Once the 60 days are exhausted, the employee's current sick-leave (0-10 days) is used and the employee may elect to use his/her accumulated sick leave.
- **Sub-Differential or 50% Pay (*Ed Code* §44983 and §44977) –** Once the 60 days and sick-leave have been exhausted, the employee is entitled to sub-differential which is the difference between the employee's full salary and the cost to hire a replacement (sub), or 50% pay, which is just that, 50% of his/her pay.

Classified:

- **60 Days -** 60 days of full salary per injury starts day one. The District makes up the difference between temporary disability income and the employee's regular pay.
- **Sick Leave, Vacation and Compensating Time (pro-rated on an hourly and daily basis) -** Once the 60 days are exhausted, the employee's current (0-10 days) and accumulated sick leave, vacation and compensating time are then used.
- **Sub-Differential or 50% Pay (*Education Code* §45196) –** Once the 60 days and all compensating time has been exhausted, the employee is entitled to Sub-Differential which is the difference between the employee's full salary and the cost to hire a replacement (sub), or 50% pay, which is just that, 50% of his/her pay.

PERMANENT DISABILITY:

Once your condition has reached maximum medical improvement your physician will issue a final report. The final report will address, if applicable, the need for future medical care and any permanent impairment you may have sustained.

INFORMATION FOR INJURED WORKERS

QUALIFIED MEDICAL EVALUATIONS:

If your claim is delayed pending a medical determination regarding causation or if you disagree with the findings of your primary treating physician, you have the right, **at no cost to you**, to request an evaluation by a state Qualified Medical Evaluator.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS (SJDB):

If you are unable to return to work after you have reached maximum medical improvement in relation to your work-related injury or illness, you may be entitled to an SJDB voucher if you have permanent impairment. The voucher is to assist with retraining or skill enhancement. This voucher can be used for schooling, counseling and supplies to train for a new occupation.

DEATH BENEFITS:

Qualified dependents will be awarded benefits set forth by the Workers' Compensation Appeals Board and up to $10,000 to cover funeral costs.

DELAYED CLAIMS:

If additional information is needed to decide the compensability of your claim, your claims adjuster has a legal obligation to conduct an investigation and has up to 90 days, from the date you filed your Workers' Compensation Claim Form (DWC-1), to make a determination. While your claim is delayed, you will be entitled to **medical treatment up to $10,000** pending a decision to accept or reject your claim.

Failure to cooperate with the investigation may result in your claim being denied.

ATTORNEYS:

It is not necessary to be represented by an attorney to receive these benefits. However, you do have the right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

ADDITIONAL RESOURCES:

The state of California offers an Information and Assistance Officer free of charge to help you in answering questions or filling out forms should there be any problems with your case. The San Bernardino Information and Assistance Officer may be reached at (909) 383-4522 or you may receive recorded information by calling 1-800-736-7401. You can also visit the State's website at: www.dwc.ca.gov.

DISCRIMINATION:

It is a violation of Labor Code section 132(a) and illegal for your employer to terminate or punish you for filing a workers' compensation claim or testifying in another person's workers' compensation claim. Discrimination can result in increased benefits and reimbursement of lost wages and or benefits.

WORKERS' COMPENSATION FRAUD IS A FELONY

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

FINES CAN BE UP TO $150,000 AND IMPRISONMENT UP TO 5 YEARS.

OCCUPATIONAL CLINIC – EMPLOYEE SATISFACTION SURVEY

Our employees are very important to us and we want to ensure they receive the best medical care and treatment when they sustain an injury or illness on the job. To help in this endeavor we would appreciate your personal feedback pertaining to your experience with the occupational clinic you were first referred to. Your feedback will assist us in providing feedback to the clinics we use and assist in selecting quality physicians and clinics. Thank you for your time.

PLEASE COMPLETE AND RETURN TO YOUR EMPLOYER'S WORKERS' COMPENSATION COORDINATOR

Employee Name: _____
Date of Exam: _____
Date of Injury/Illness: _____
Name of Medical Facility: _____
Name of Physician: _____

Please Rate the Following:

1.	How courteous was the receptionist	Excellent	Good	Fair	Poor	N/A
2.	Did the physician give you a sense of caring	Excellent	Good	Fair	Poor	N/A
3.	Overall care given to control pain and discomfort	Excellent	Good	Fair	Poor	N/A
4.	The amount of time the physician spent with you	Excellent	Good	Fair	Poor	N/A
5.	Explanation from the physician about your treatment plan	Excellent	Good	Fair	Poor	N/A
6.	Your level of comfort with the physician's explanation	Excellent	Good	Fair	Poor	N/A
7.	The time the physician spent with you	Excellent	Good	Fair	Poor	N/A
8.	How would you rate the physical exam	Excellent	Good	Fair	Poor	N/A
9.	Your confidence with the physician	Excellent	Good	Fair	Poor	N/A
10.	Rate overall appearance of the facility	Excellent	Good	Fair	Poor	N/A

11. Do you feel more should have been done to improve your visit? ☐ Yes ☐ No
If Yes, please explain:

12. How likely are you to recommend the clinic to a co-worker?

1	2	3	4	5	6	7	8	9	10

Not at all likely — Extremely Likely

13. Please feel free to expand on any question or comment you would change about your office visit to improve service:

WORKERS' COMPENSATION REQUEST FOR MEDICAL TREATMENT

ACKNOWLEDGMENT FORM

I am requesting medical care for my injury or illness which occurred on _____ and I have received the following:
(Date of Injury)

- ☐ Workers' Compensation Claim Form (DWC-1)
- ☐ Employee Report of Incident Form (CSRM WC 101)
- ☐ WellComp Medical Provider Network Pamphlet
- ☐ MyMatrixx Temporary Prescription Form
- ☐ Employee Satisfaction Survey Form (CSRM WC 104)
- ☐ Information for Injured Workers (CSRM WC 103)

I UNDERSTAND it is my responsibility to fill out the Employee Claim Form (DWC-1) and return it to my employer. Failure to do so may affect my entitlement to Workers' Compensation benefits.

Employee initial here: _____

I UNDERSTAND that while I am receiving **Salary Continuation** and or **Temporary Disability Benefits**, I am **REQUIRED** to report **ANY earnings or income** from any source to my claims adjuster as it may affect my entitlement to benefits. Failure to disclose this information may result in prosecution for violation of the Workers' Compensation Fraud law, and, if convicted, may result in a felony.

Employee initial here: _____

I UNDERSTAND if I am offered a temporary modified or alternate work assignment it is my duty to show for the assignment and if I choose not to accept the assignment, I **MAY NOT** be eligible for **Salary Continuation** and or **Temporary Disability Benefits**.

Employee initial here: _____

I UNDERSTAND that following my medical evaluations I am to provide a copy of my work status to the person designated by my employer.

Employee initial here: _____

I UNDERSTAND anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony, and may be punished by imprisonment in county jail for one year, or in state prison for up to **5 years, and/or fined up to $150,000** or double the value of the fraud (whichever is greater), and ordered to pay restitution as determined by the court. (Ins. Code 1871.4)

Employee initial here: _____

Employee Signature: _____ Date: _____

Employee Print Name: _____ SSN#: _____

Employer Name: _____

Department: _____

Employer Signature: _____ Date: _____

Employer Print Name: _____

EMPLOYEE'S REPORT OF INCIDENT

Instructions: Employees shall use this form to report all work-related incidents – ***no matter how minor the incident may appear.*** This helps us to identify and correct situations before they cause serious injuries. This form shall be completed by employees as soon as possible and given to their supervisor for further review and action.

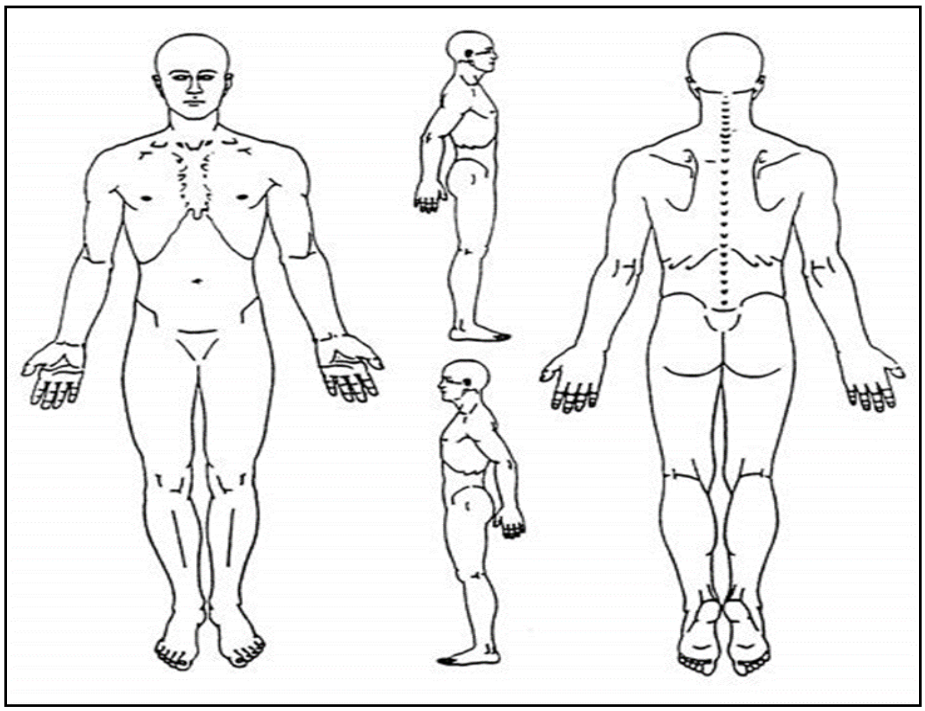
Employee Name:				Date of Birth:	
Occupation:			Department/Site:		
Employee Phone:		Employee Email:			
Date of Incident:		Time of Incident:	_____ AM_____ PM		
On Employer's Property?	☐ Yes ☐ No				
Location of Incident:					

Describe what you were doing at the time of the incident:
Describe how the incident occurred:
If this was a motor vehicle accident was a police report taken? ☐ Yes ☐ No If "Yes," which police department took the report?
Was any other person injured? ☐ Yes ☐ No If "Yes," please list:
Were any tools, equipment or motorized vehicles involved with the incident? ☐ Yes ☐ No If "Yes," please explain:
Could something been done to prevent the incident from occurring? ☐ Yes ☐ No If "Yes," please explain: (equipment, tools, assistance, judgement, etc.)
Please describe any safety hazard(s) you observed:
List all witnesses or those, other than your supervisor, you reported the incident to:

Supervisor's Name:	
Supervisor's Phone:	
If you did not report the incident to your supervisor, who did you report the incident to?	
Did you receive a claim form (DWC-1)?	☐ No ☐ Yes Date: _____
Did you sign and return the claim form?	☐ No ☐ Yes Date: _____

Employee Name:		Date of Incident:	

CIRCLE AREA(S) OF INJURY OR SYMPTOMS AND LIST BELOW



MAIN COMPLAINTS

__ Bruise/Contusion
__ Dislocation
__ Dizziness/Nausea
__ Dull Ache
__ Gastrointestinal Trouble
__ Heat Related
__ Immobile Joint/Appendage
__ Numbness/Tingling
__ Obvious Fracture/Deformity
__ Possible Concussion
__ Respiratory Trouble
__ Skin/Rash/Dermatological
__ Sharp Pain
__ Strain/Sprain
__ Visible Swelling
__ Vision Trouble
__ Wound – Abrasion
__ Wound – Laceration

Describe the injury or illness (body part(s) condition):
Have you ever sustained an injury or illness to this part of your body before? ☐ Yes ☐ No If "Yes," please explain any previous condition that may have been aggravated by this incident:

CHECK AND INITIAL NEXT TO THE OPTION BELOW THAT APPLIES

☐ **Medical Treatment Requested:** I am requesting medical treatment for my injury or illness.
Employee initial here: _____

☐ **Declination of Medical Treatment:** I am reporting the injury or illness for **REPORTING PURPOSES ONLY** and declining medical attention at this time. My declination is not a waiver of Workers' Compensation benefits. I understand I have **one (1) year** from the date of this incident to request medical treatment and/or benefits under Workers' Compensation (California Labor Code 5405(a)).
Employee initial here: _____

If I elect to seek medical attention for the injury or illness, in the future, I will **immediately** advise my supervisor and/or employer and will be referred for treatment within 24 hours.
Employee initial here: _____

_____ _____
Employee Signature Date

☐ **Mark if attachments are included**

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

Employee Name:		Date of Birth:	
Employee Occupation:		Department/Site:	
Employee Phone:		Employee Email:	

Date of Incident:		Time of Incident:	_____ AM _____ PM

On Employer's Property? ☐ Yes ☐ No

Location of Incident:

Date Incident Reported:		Reported Within 24 hours: ☐ Yes ☐ No	

If not reported within 24 hours explain why:

Was employee provided a claim form (DWC-1)? ☐ No ☐ Yes Date: _____

Did employee sign and return the claim form? ☐ No ☐ Yes Date: _____

Type of medical treatment required:

- ☐ Clinic
- ☐ Emergency room
- ☐ Paramedics or EMT
- ☐ Hospitalized overnight
- ☐ First Aid
- ☐ Medical treatment refused
- ☐ No treatment needed

Was OSHA Notified ☐ YES ☐ NO

If Yes, complete

By whom: _____

Date: _____ Time: _____

OSHA Confirmation #:

Medical treatment provider (name and address of facility):

Name and title of person to whom the incident was reported:	

Describe what was the employee doing at the time of the incident? (attach separate sheet, if necessary)

Describe how the incident occurred: (attach separate sheet, if necessary)

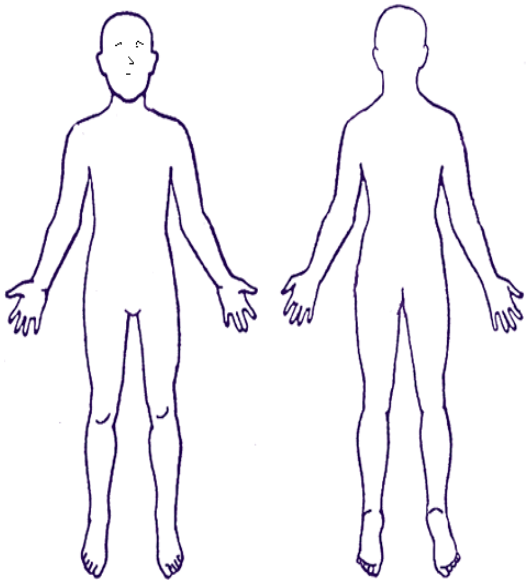
Type of Injury:

- ☐ Amputation/severance
- ☐ Bite/sting
- ☐ Burn
- ☐ Cancer
- ☐ Contusion, blunt trauma
- ☐ Crush
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Fracture
- ☐ Inflammation
- ☐ Internal
- ☐ Puncture, penetrating trauma
- ☐ Repetitive motion injury
- ☐ Sprain/strain
- ☐ Tendonitis/synovitis
- ☐ Other: _____

Cause of Injury:

- ☐ Absorption, ingestion, inhalation
- ☐ Animal or insect
- ☐ Burn, scald, temperature extreme
- ☐ Caught in or between
- ☐ Cumulative Trauma
- ☐ Cut, puncture or scrape
- ☐ Electrical current
- ☐ Equipment, tools, machinery
- ☐ Explosion
- ☐ Foreign body
- ☐ Lifting
- ☐ Motor vehicle
- ☐ Pushing, pulling
- ☐ Repetitive motion
- ☐ Rubbed or abraded
- ☐ Slip, trip or fall
- ☐ Struck against, by
- ☐ Miscellaneous causes
- ☐ Other: _____

Mark affected area(s) on diagram:



Employee Name:		Date of Incident:	

Did employee lose time from work? ☐ No ☐ Yes **First day of lost time:**

Has employee returned to work? ☐ No ☐ Yes **Date returned:** _____
☐ Full Duty
☐ Modified Duty – Describe:

Was the incident witnessed? ☐ Yes ☐ No (list witnesses below. Attach separate sheet, if necessary)

Name:	Name:
Address:	Address:
City, State Zip:	City, State Zip:
Phone:	Phone:

Was any other employee injured? ☐ Yes ☐ No If "Yes," please list:

Check all conditions that apply:

Equipment
- ☐ Defective machine
- ☐ Machine guards not in place
- ☐ Improper tools
- ☐ Defective tools
- ☐ Improper protective equipment
- ☐ Defective protective equipment
- ☐ Inadequate protective equipment
- ☐ Other: _____

Procedure
- ☐ Unsafe procedures
- ☐ Procedures missing
- ☐ Procedures inadequate
- ☐ Other: _____

Training
- ☐ Employee(s) lack training
- ☐ Employee(s) needs training
- ☐ Other: _____

Supervision
- ☐ Procedures not enforced
- ☐ Use of protective equipment not enforced
- ☐ Use of proper equipment not enforced
- ☐ Other: _____

Worker
- ☐ Horseplay, unsafe behavior
- ☐ Short cuts, carelessness
- ☐ Distracted, inattentive
- ☐ Other

Environment
- ☐ Arrangement of equipment, workflow, tools
- ☐ Poor housekeeping
- ☐ Inadequate lighting

Environment
- ☐ Inadequate ventilation
- ☐ Signs – inadequate signs or other warnings
- ☐ Walking surface

Describe steps recommended or taken to prevent a recurrence:

List any damaged employer property:

Was the event caused by a third-party? ☐ No ☐ Yes, complete below

☐ Auto accident ☐ Rented or leased equipment ☐ Off-site activity ☐ Conference or seminar ☐ Construction area

Name and Address of third-party:

Description of involvement:

Other information:

Photographs taken? ☐ No ☐ Yes, by whom: _____

Police or Fire called? ☐ No ☐ Yes, by whom: _____

Evidence preserved (contact safety or risk management)? ☐ No ☐ Yes, by whom: _____

Completed by (print name): _____ Phone: _____

Signature: _____ Date: _____

☐ **Mark if attachments are included**

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

Please complete in triplicate (type if possible) Mail two copies to:
Sedgwick P.O. Box 619179, Roseville, CA 95661

OSHA CASE NO.

FATALITY ☐

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

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

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF NJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

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

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

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

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

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

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY