



Workers' Compensation Program

TABLE OF CONTENTS

I.	PROGRAM OVERVIEW	
	Program Structure _____	1
	Program Flow Chart _____	2
II.	GENERAL INFORMATION	
	Covered Liabilities _____	3
	W. C. Benefits _____	4
	Settlements/Closure Definitions & Abbreviations _____	5
	OSHA Reporting Requirements _____	8
III.	BEFORE A CLAIM OCCURS	
	Pre-Designated Physician Background _____	9
	Pre-Designated Physician Procedures _____	10
	Designated Hospitals/Clinics _____	11
	Sample Memo & Form _____	12
	MPN (Medical Provider Network) Info _____	14
	Annual Checklist _____	15
IV.	WHEN A CLAIM OCCURS	
	Supervisor Procedures _____	16
	Company Nurse Frequently Asked Questions _____	17
	District Office Procedures _____	18
	Notice & Filing Requirements _____	19
V.	ONCE A CLAIM HAS BEEN FILED	
	Tips On Claims Handling _____	20
VI.	RETURN TO WORK	
	On Call Reporting & Return To Work _____	21
	Dept. of Ind. Relations Administrative Rules _____	23
	Forms – Notice of Offer of Regular Work _____	26
	Sample Board Policy _____	30
	Sample Administrative Regulations _____	31
VII.	PENALTIES	
	Self-Imposed, Serious & Willful, 132A Claims _____	32
VIII.	CERTIFICATES OF INSURANCE	
	How To Obtain A Certificate _____	33
IX.	INDUSTRIAL/ILLNESS, FMLA, CFRA LEAVE INFORMATION	34
X.	OTHER FORMS	
	Employers Report Of Occupational Injury Or Illness Form 5020	
	Employee's Claim For Workers' Comp. Benefits Form DWC-1 (3pages)	
	Supervisor's Report of Injury/Illness	
	Medical Authorization Form	
	Log For Dispensing Employee Claim Forms (DWC-1)	
	Notice Of Employee Death	
	Claim Retraction Form	
	Facts About Workers' Compensation Pamphlet (In front pocket of binder)	
	MPN Pamphlet (In front pocket of binder)	

I. Program Structure



Central Region School Insurance Group

Workers' Compensation Program Structure 2010/11

Safety National (Reinsurance)	\$1,000,000 - Statutory
CRSIG SIR (Self-Insured Retention)	\$1,000,000
Member District Deductible	\$0

Claims Reporting & Administration

York Insurance Services Group, Inc.
PO Box 619079
Roseville, CA 95661-9058

For all new work related injury and illness:

Pam Viglietti

(Last Names: M-Z)

Toll free: 800-922-5020

Direct: 916-960-0966

Fax: 866-548-2637

pamela.viglietti@yorkisg.com

For open claims:

Simonne Greene

(Last Names: A-L)

Toll free: 800-922-5020

Direct: 916-960-0922

Fax: 866-548-2637

simonne.greene@yorkisg.com

Claims Supervisor for CRSIG account:

Kim Silas

Toll free: 800-922-5020

Direct: 916-960-0993

Fax: 866-548-2637

kim.silas@yorkisg.com

Certificates of Insurance

Wells Fargo Insurance Services

P.O. Box 1106

Grass Valley, CA 95945

gail.blagg@wellsfargo.com

Gail Blagg

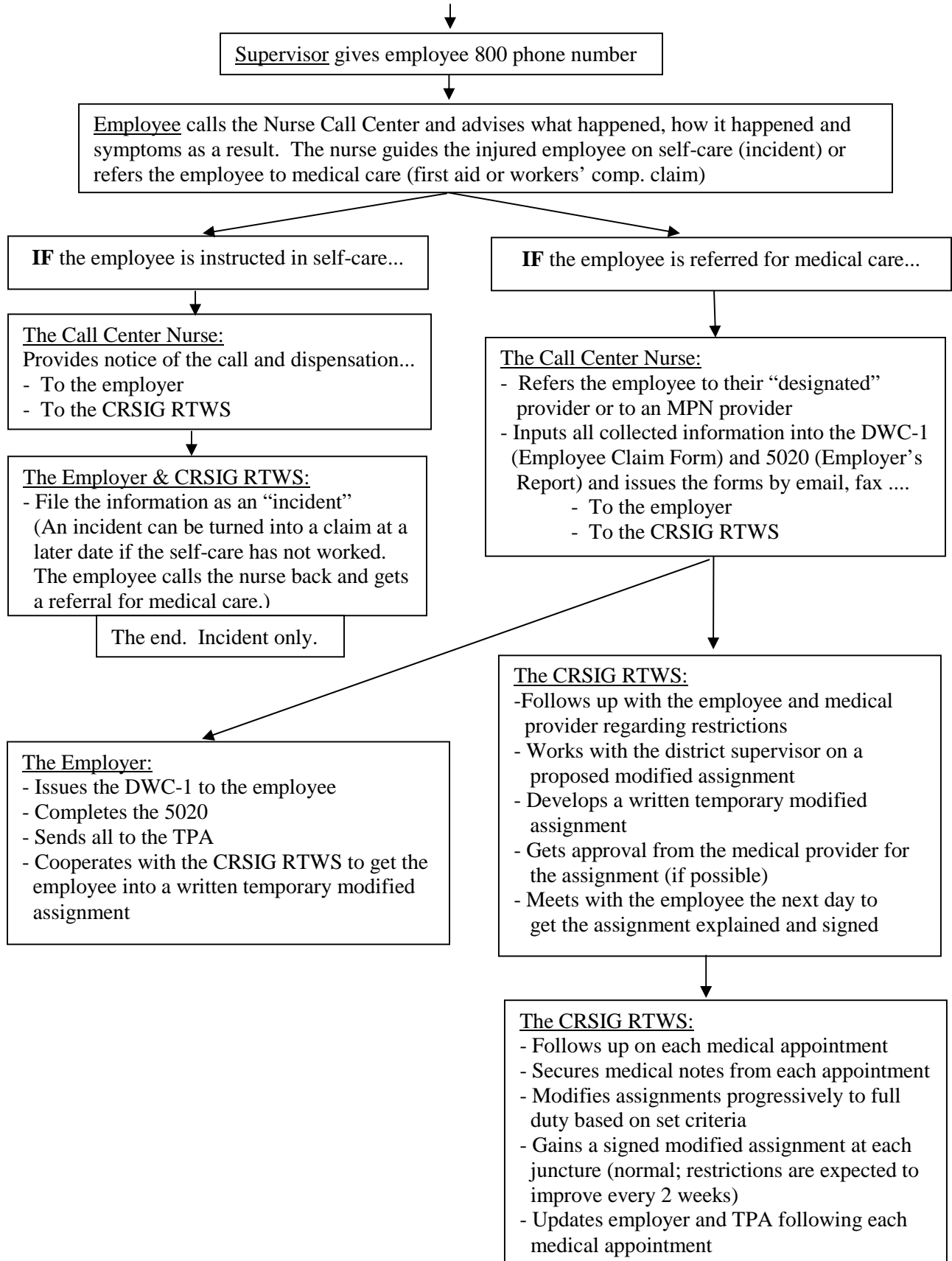
Phone: (530) 271-2722

Toll Free: (888) 298-7213

Fax: (530) 273-6459



Claim Reporting & Return-To-Work Program Flowchart



II. General Information

WORKERS' COMPENSATION COVERED LIABILITIES

- * A state mandated benefit program to aid injured workers.
- * Paid at 100% by the employer.

What Is Covered:

- * An injury or illness occurring as a result of employment.

What Is Not Covered:

- * Injuries occurring outside the scope and course of employment
- * Personal illness
- * Intentional self-inflicted injuries
- * Injuries due to intoxication
- * Injuries due to personal disputes or altercations
- * Suicide
- * Injuries caused during the commission of a felony
- * Off duty recreational, social or athletic activities

No Fault System:

- * Benefits are payable regardless of employee fault or negligence.
- * Employer has burden of proof on disputed claims.

WORKERS' COMPENSATION BENEFITS THAT ARE COVERED

Medical Care:

- * All services necessary to cure or relieve from the effects of injury or Illness
- * Mileage reimbursement

Temporary Disability:

- * Wage loss compensation
- * Following Ed. Code Provisions, Two-thirds of average weekly wages
- * Maximum per week is set by the State of California

Permanent Disability:

- * Compensation for permanent impairment
- * Maximum of weekly payments are set by the State of California

Vocational Rehabilitation:

- * One time voucher payment

Death Benefits:

- * Maximum benefit is set by the State of California

Settlement/Claims Closure Definitions

Although a claim can be settled in a variety of manners, this may not necessarily mean that the case is closed. The following is a listing of various settlement processes and closing mechanisms.

Stipulation (STIP)

- Settles permanent disability only
- Paid weekly until award is paid in full
- Future medical may be left open
- Can file for “new & further “ permanent disability within 5 years from date of injury
- Never includes Vocational Rehabilitation Benefits
- Parties can enter into a C&R for future medical care at a later date

Compromise & Release (C&R)

- Paid in one lump sum
- Usually includes future medical benefits
- May include vocational rehabilitation if:
 - Injury is disputed
 - Retro benefit issue is raised and an amount agreed upon.
- Eliminates future exposure for new and further permanent disability Unless a new injury occurs

Findings & Award (F&A)

- Settles Permanent Disability
- Determined by the WCAB after trial
- May allow future medical care
- Can be appealed
- Parties can enter into a C&R for future medical care at a later date

Closings:

- Self-Insured claims can be “administratively closed” if there has been 2 years of inactive medical treatment. These cases usually involve cases settled by way of Stipulation or Findings & Award with open medical treatment. If future medical treatment has not been settled, the claim cannot be archived and cannot be destroyed.
- Fully-Insured claims can be closed within 6 months of inactive medical treatment.
- **Once all issues have been resolved and settled, via Compromise and Release or Findings and Award, which settles Future Medical care, the claim can be closed entirely. 7 year anniversary date from date of closure for destruction of file.**

COMMON ABBREVIATIONS USED IN THE W.C. INDUSTRY

A/A:	Applicant Attorney
A.C.O.E.M.	American College of Occupational & Environmental Medicine
ADA:	American's w/Disabilities Act
A.D.:	Administrative Director
A.M.A.	American Medical Association
A.M.E.:	Agreed Medical Evaluator
A.W.W.:	Average Weekly Wage
AOE/COE:	Arise out of employment/Course of employment
CLMT:	Claimant
C&R:	Compromise & Release
D.E.U:	Disability Evaluation Unit
D.O.R.:	Declaration of Readiness
D.W.C.:	Division of Workers' Compensation
E.D.D.:	Employment Development Department
EE:	Employee
ER:	Employer
F&A:	Findings & Award
FMLA:	Family Medical Leave Act
FEHA:	Fair Employment & Housing Authority
I&A Officer:	Information & Assistance Officer
I.M.C.:	Industrial Medical Council
I.M.E.:	Independent Medical Examiner
I.V.E.:	Independent Vocational Evaluator
I.W.:	Injured Workers
J.A.:	Job Analysis
L.D.W.:	Last Day Worked

L.E.:	Life Expectancy
L.P.:	Life Pension
M.M.I.	Medical Maximum Improvement
M.S.C.:	Mandatory Settlement Conference
OSHA:	Occupational Safety and Health Act
P.D.:	Permanent Disability
P.D.A.:	Permanent Disability Advance
P&S:	Permanent & Stationary
Q.I.W.:	Qualified Injured Worker
Q.M.E.:	Qualified Medical Evaluator
Q.R.R.:	Qualified Rehabilitation Representative
Recon:	Petition for Reconsideration
R.T.W.:	Return to Work
R.R.T.W.:	Released to Return to Work
R.U.:	Rehabilitation Unit
S.D.I.:	State Disability Insurance
S.I.P.:	Self-Insurance Plans
SSSOP:	Spinal Surgery Second Opinion Process
Stips:	Stipulations with Request for Award
S&W:	Serious & Willful Misconduct
T.T.D.:	Temporary Total Disability
T.P.D.:	Temporary Partial Disability
U.R.	Utilization Review
V.R.M.A.:	Vocational Rehabilitation Maintenance Allowance
W.C.A.B.:	Workers' Compensation Appeals Board
W.C.I.R.B.:	Workers' Compensation Insurance Rating Bureau
W.C.J.:	Workers' Compensation Judge
W.L.:	Wage Loss
W.P.:	Waiting Period

OSHA Reporting Requirements

Effective January 1, 2003 the minimum civil penalty was increased to \$5,000.00 for failure to report a fatality or serious injury or illness to the Division as required by section 342 of Title 8 of the California Code of Regulations. Only the amount of the penalty has been changed, not the reporting requirements. For your information the following is a summary of the reporting requirements:

Employers Reporting Responsibilities To CAL/OSHA Pertaining to On-The-Job Injuries and Illnesses

Incidents requiring reporting to the Division within 8 hours:

- Fatal injury to an employee
- Serious injury or illness to employee

A serious injury or illness is defined as:

- Loss of a member of the body (e.g., amputation); or
- Serious degree of permanent disfigurement (e.g., crushing or severe burn type injuries); or
- In-patient hospitalization in excess of 24 hours for other than observation,

Employers are not required to report any injury or illness or death caused by an accident on a public street or highway, or by the commission of a Penal Code violation, except a violation of section 385 of the Penal Code which addresses high voltage electrical conductors.

If a fatal or serious injury or illness to an employee occurs, the employer must report by telephone or fax to the nearest district office of the Division not longer than 8 hours after the employer knows or with diligent inquiry would have known of the incident.

**CAL/OSHA
Modesto Office
4206 Technology
Suite 3
Modesto, CA 95356
209-545-7310
(Fax) 209-545-7313**

Information required to be reported to the Division:

1. Time and date of accident.
2. Employer's name, address and telephone number.
3. Name and job title, or badge number of person reporting the accident.
4. Address of site of accident or event.
5. Name of person to contact at site of accident.
6. Name and address of injured employee(s).
7. Nature of injury.
8. Location where injured employee(s) was (were) moved to.
9. List and identity of other law enforcement agencies present at the site of accident.
10. Description of accident and whether the accident scene or instrumentality has been altered.

III. Before A Claim Occurs



Central Region School Insurance Group

DESIGNATED PHYSICIAN PROGRAM BACKGROUND

In an ongoing effort to help reduce the cost of Worker's Compensation Claims, CRSIG makes use of a Designated Physician Program.

Under this program, the member school District can benefit themselves and other CRSIG members while providing quality medical care. The intent of the program is to direct 100% of all injured employees to facilities that have physicians trained to treat work related injuries or illnesses. When we direct employees to our facilities, cost savings in medical billings, indemnity, and other related expenses will be reduced. By reducing these costs, members benefit from reduced premiums, since premiums are modified by costs involved in the injury. Many regular doctors are unwilling or unable to treat occupational injuries or illnesses. Physicians in the CRSIG Occupational Medical Treatment Facilities are geared to treat workplace injuries and know the proper paperwork procedures and acceptable methods of treatment as designated by current guidelines.

In the event an employee sustains an injury or illness related to their on-the-job employment, they may be treated for such injury or illness by their personal medical doctor (MD), personal medical facility or doctor of Osteopathy (DO) if:

- Ø Their employer offers group health coverage;
- Ø The doctor is their regular physician, has previously directed their medical care and retains their records;
- Ø Prior to injury their doctor agrees to treat them for a work related injury or illness, preferably in writing;
- Ø Prior to their injury the employee provided to the employer in writing: (1) notice that they want their personal doctor to treat them for a work-related injury or illness, and (2) the doctor's name and business address.

The following page lists the medical providers that have been selected by the Central Region School Insurance Group for all district members as designated providers for the evaluation and treatment of work related injuries and illnesses.

CRSIG
DESIGNATED PHYSICIAN PROGRAM PROCEDURES

Designated Physician Procedure: MUST BE PERFORMED ANNUALLY

1. The California Workers' Compensation "If A Work Injury Occurs..., Workers Compensation Benefits Include..." should be posted in work areas. Additional copies of the posters may be obtained by contacting the CRSIG at (209) 579-7535. This poster includes notification to employees of the district's designated physicians and facilities.
2. Each year you must notify all employees/substitutes of the district's designated physician/facility and of his/her option to choose his/her own designated physician/facility. This is accomplished by distributing to all employees and substitutes the following forms:
 - Sample Memorandum
 - CRSIG Designated Physicians & Clinics
 - Pre-Designated Treating Form
 - Facts for Injured Workers
3. Employees wishing to pre-designate their own physician/facility for treatment must complete the Pre-Designated Physician Form and return it to your district office by the return date indicated on the Memorandum. Any employee who does not return a pre-designated physician/facility form should be treated by the district's designated physician/facility should they sustain an industrial injury/illness.
4. When you receive a Pre-Designated Physician Form from an employee, you need to keep the form on file in case the employee sustains an industrial injury or illness in the future.
5. A copy of all Pre-designated Physician Forms should be forwarded to your claims adjuster at York Insurance Services Group, Inc. when a claim occurs.
6. When an employee is injured, the district should refer the employee for treatment based upon any pre-designations on file.

CRSIG Designated Physicians & Clinics

Memorial Hospital (Emergency Only)
1700 Coffee Road, Modesto, CA 95355 (209) 526-4500

Doctors Medical Center (Emergency Only)
1441 Florida Avenue, Modesto, CA 95350 (209) 578-1211

Emanuel Medical Center (Emergency Only)
825 Delbon Ave, Turlock, CA 95382 (209) 667-4200

Sutter Gould Occupational/Acute Care - Modesto
600 Coffee Road, Modesto, CA 95355 (209) 524-1211

U.S. HealthWorks
1524 McHenry Ave, Ste 500, Modesto, CA 95350 (209) 575-5801
1340 Mitchell Rd., Modesto, CA 95351 (209) 581-9711

Sutter - Patterson
801 E. Street, Patterson, CA 95363 (209) 892-2081

Work Wellness Center of Occupational Medicine Clinic
Mike Romeo,MD, Sam Romeo,MD, Chris Hawly,MD, Ken Honsik, MD (209) 216-3333
1801 Colorado Ave, Suite 130, Turlock, CA 95382

IMPORTANT: UNLESS AN EMPLOYEE HAS ON FILE A REQUEST TO BE TREATED BY HIS/HER OWN PHYSICIAN, PAYMENT WILL NOT BE MADE OTHER THAN TO THE DISTRICT'S DESIGNATED PHYSICIAN/FACILITY.
SAMPLE DESIGNATED DOCTOR FORM MEMORANDUM

TO: All District Employees

FROM: District Office

SUBJECT: Procedures for Medical Treatment of Work-Related Injuries

Attached is information regarding Workers' Compensation benefits. In order to provide immediate appropriate medical care and control the high cost of workers' compensation coverage, the District has established procedures for the handling of work-related injuries and illnesses.

Designated Physician/Facilities:

The District is permitted by statute to control medical treatment of work-related injuries for the first thirty (30) days from when the injury was reported, and has designated a physician/facility for the convenience of the employees. The list of physicians designated for the purpose of medical care in the event of a work-related injury/illness is attached.

Employees, however, who have notified the district in writing prior to the date of injury, of the desire to be treated by a personal physician (see attached Pre-Designated Physician Form) may be immediately treated by their own physician once the District has verified that the physician is able and willing to treat industrial injuries/illnesses. Labor Code Section 4600 defines personal physician as "...the employee's regular physician and surgeon...who has previously directed the medical treatment of the employee, and who retains the employee's medical record, including his or her medical history".

This notification of personal physician/medical facility must be returned to _____ by _____.

Please be aware, personal chiropractors may not be pre-designated due to the utilization of the MPN (Medical Provider Network).

If you do not pre-designate a personal physician or medical facility, after initial treatment with the district's designated physician/facility you may request a one-time change of physician. If an employee so requests, the Third Party Administrator shall offer the employee one change of physician.



**Central Region
School Insurance Group**

PRE-DESIGNATED PHYSICIAN FORM

This Section to be completed by employee:

Date: _____

Employee Name: _____ Position: _____

In the event of any on-the-job, work-related injury, I request that I be treated by my personal physician as indicated below:

Personal Physician: _____

Physician's Address: _____

Physician's Phone Number: _____

Important Requirements for Personal Physicians:

- § The physician is the employee's regular physician (MD), licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.
- § The physician is the employee's primary care physician under their medical plan and has previously directed the medical treatment of the employee, and retains the employee's medical records, including his or her medical history.
- § The physician agrees to be pre-designated and has signed approval below.

Employee Signature: _____

Date: _____

.....
This section to be completed by Personal Physician:

I agree to be the Pre-Designated Physician for the above-referenced individual for the treatment of work-related injuries. I understand that payment will be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1 of the Labor Code in effect on the date of service. Payments shall be made by the employer within 45 working days after receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician.

Physician's Signature: _____

Date: _____

CRSIG Medical Provider Network History & Background

Historically, the Central Region School Insurance Group utilized the Horizon Managed Care (HMC) Medical Provider Network (MPN) for treatment of industrial injuries from October 28, 2005 through April 30, 2009. Starting May 1, 2009, CRSIG changed its MPN with the State of California to the WellComp Network.

The MPN culminated from the workers' compensation reform in the early 2000's. An MPN provides employers in the State of California with the ability to utilize medical providers that specialize in the treatment of industrial injuries. The State of California, Division of Workers' Compensation reviewed and approved the network as required by the legislation.

Pursuant to regulations, CRSIG produced informational booklets, in both English and Spanish, explaining the MPN and the implementation of the new standards. *The State mandates that the employer provide each injured and new employee with a copy of the booklet following initial implementation of the network and upon the implementation of a new network. It is imperative that the District document when and who receives the booklets*

To access the online listing of providers, you can visit the WellComp Network website and take the following steps.....

- 1) www.WellComp.net
- 2) Go to "find a provider"
- 3) Enter your school district's name
- 4) Continue
- 5) You can search by: Name, Location, City, Zip Code, County or Area Code
- 6) Choose a Specialty
- 7) Search by Radius –You may choose from 5 to 60 miles
- 8) Go to "find your provider"
- 9) You can choose a specific group, physician or you may print the entire list.

Checklists

Designated Doctor Program Check List (To be performed annually)

- 1. Notice sent out to all employees and substitutes. Packet includes:
 - Sample Employee Memorandum
 - Pre-Designated Physician Form
 - List of CRSIG Designated Physicians & Clinics

- 2. Double check that required posting is up in areas visible to all employees.
 - California “If A Work Injury Occurs..., Workers Compensation Benefits Include...”

- 3. Filing of all documents relating to employee designations. Filing includes:
 - Pre-Designated Physician Form

MPN Check List

- 1. Send copy of the MPN Booklet to each new employee and employees who have sustained an injury or illness.

IV. When A Claim Occurs

Workers' Compensation Injury/Illness Reporting Procedures

(Employee reports injury/illness to supervisor)

I. SUPERVISORS:

1. **Apply first aid** if trained staff is available. **If a serious injury has occurred, ensure immediate emergency care for the employee.**
2. **Direct the injured employee to contact the Company Nurse call line** to report the injury and obtain authorization for medical care if it is needed. If the employee has filed a pre-designated physician form with the school district, please remind the employee to let the nurse know when Company Nurse is contacted.

The toll free phone number is **1-877-247-1445**

This phone line is available 24 hours per day, 7 days per week, 365 days per year.

NOTE:

- a) If you have ensured immediate emergency care for the employee, you will need to contact the district office immediately and contact the Company Nurse call line to report the injury and referral for care on behalf of the employee.)
 - b) When injured employees contact the Company Nurse call line, an automated notice will be sent to the district office and CRSIG Return To Work Specialist regarding any referrals for medical care or claim initiated.
3. **Advise the employee that they must return a Doctor's Note/Work Status Report** prior to returning to work, and after each medical appointment. The CRSIG Return To Work Specialist will be contacting you to arrange for a temporary work assignment if the physician assigns restrictions.
 4. The district office will receive a Supervisor's Report from Company Nurse and will contact you if additional information is needed.

Background

On 10/1/08 CRSIG implemented the Company Nurse Call Line for reporting work related injuries and illnesses. Employees are able to speak with a nurse within minutes of an injury occurring. Nurses make medical decisions on whether self-care instruction will be provided or if the employee needs to be referred for medical care.

Company Nurse Frequently Asked Questions

Q. Should I call Company Nurse after every workplace injury?

A. Yes, every injury should be called in to Company Nurse. CALL COMPANY NURSE BEFORE THE EMPLOYEE LEAVES THE JOB SITE. This will immediately provide injury information to the District and RTW Specialist on every injury. This is a 24/7 service, including all holidays.

Q. The employee has been referred for treatment but doesn't feel the injury needs to be treated, should I send him/her anyway?

A. Yes. It is always best to follow the advice of the RN and get treatment sooner than later. Minor injuries are often referred to seek treatment within 48-72 hours. If the employee refuses to seek treatment, that will be documented in the incident report.

Q. The employee does not want to call Company Nurse. Should I call it in myself?

A. Yes. Call with the information that you have; try to include where the employee was treated if that is the case. The reports will be forwarded to the District and RTW Specialist for appropriate action.

Q. The employee has already been treated by their own physician. Should I have him/her call it in?

A. Yes. Have the employee call Company Nurse with information about their injury and where the treatment took place so a report can be generated.

Q. What will I hear when I call Company Nurse?

A. After the 911 message, you will have the following options: Option 1 for English or Option 2 for Spanish... Then listen carefully to all options that will then guide you to the appropriate agent.

Q. What happens if the Nurses are flooded with calls? I don't want to be on hold forever.

A. The protocol is to answer every call that comes in – there is no voicemail box on the line. Most calls are initially answered by a medical clerk or health information assistant (HIA). During unexpected high volume time periods, the clerk will take your phone number and have a Nurse call you back within a few minutes.

Workers' Compensation Injury/Illness Reporting Procedures

II. DISTRICT OFFICE:

1. **You will receive an email notice from Company Nurse regarding contact made by an injured employee.** The notice will advise you if self-care instruction was provided or if the employee was referred for medical care.
 - a. **If the employee was provided with self-care instruction,** you may file the report as an "incident only". (A DWC-1 and 5020 Form is not required.)
 - b. **If the employee was referred for medical care,** you will receive a partially populated DWC-1 Employee Claim Form and 5020 Employer's Report for completion.

2. **Send the Employee's Claim For Workers' Compensation Benefits (DWC-1)** to the injured employee for completion/signature and log this action on the Log For Dispensing Employee's Claim For Workers' Compensation.

Also, request the employee to complete a Release of Medical Authorization Form and return it with the DWC-1. While many employees may refuse to submit the form, it can greatly assist in the administration of the claim if it is received initially.

Note: The DWC-1 must be sent within 1 working day of your knowledge that an injury or illness has occurred.

3. **Send the employee an MPN (Medical Provider Network) Pamphlet.**

4. **Complete the Employer's Report of Occupational Injury or Illness (5020)**

Note: This must be completed within 5 days of your knowledge of an injury or illness

5. **Submit all forms received to York immediately.**

NOTE: When the Company Nurse has completed the call with the employee and is emailing the forms to you, the CRSIG Return To Work Specialist will also receive notice of the report and the status of any referrals.

At this point, York will be awaiting your completed reports and the Return To Work Specialist will be communicating with your office, the supervisor and physician to initiate a Temporary Work Assignment for the employee. In addition, the RTW Specialist will follow the ongoing medical care for the employee to ensure that a Doctor's Note is provided after each appointment.

CONTACT INFORMATION

York Insurance Services Group, Inc.
Pam Viglietti/Simonne Greene
P.O. Box 619079
Roseville, CA 95661-9058
Phone - Pam: 916-960-0966
Phone - Simonne: 916-960-0922
FAX: 866-548-2637
pamela.viglietti@yorkisg.com
simonne.greene@yorkisg.com

CRSIG RTW Specialist
Kari Hornberger
4101 Tully Rd., Suite 501
Modesto, CA 95356
Phone: 209-579-7535 ext 106
FAX: 209-579-5288

kari@crsig.com

Summary of Employer Notice/Filing Requirements For Workers' Compensation Claims

First Aid Claims (Effective for CRSIG districts July 1, 2007): The District is permitted by statute to treat certain work-related injuries as a first aid claim. A First Aid Claim is defined as any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care.

PROCEDURE: First aid claims are handled just like a regular workers' compensation claim at the school district level; The DWC is issued to the employee and the 5020 is completed by the employer. York however, will track claims that qualify as a first aid and pay them from a separate CRSIG trust account. This will eliminate the claim as a "workers' comp." claim for the purpose of tracking the district's claims. If at a future date, the employee's injury progresses to the need for additional medical care York will convert the First Aid Claim to a Workers' Compensation Claim

Employer's Report of Occupational Injury Or Illness Form 5020: must be completed when an occupational injury or illness results in "lost time" beyond the date of injury and/or requires medical treatment beyond "First Aid".

"Lost Time": Absence of work for a full day or shift beyond date of injury.

This form must be submitted to York within 5 days of the employer's knowledge or notification.

Employee's Claim For Workers' Compensation Benefits (DWC-1) Form: Must be provided and processed as follows:

The form must be provided to the employee within 1 working day of receiving notice or knowledge of a work-related injury or illness;

- ⇒ To the employee personally
- ⇒ Sent by first class mail

Upon receipt of a completed form from the employee, the district must date the form and provide a copy to York.

V. Once A Claim Has Been Filed

ONCE A CLAIM HAS BEEN FILED

Gather Information & Preserve Evidence

The most effective investigations are conducted immediately after an incident occurs. Witnesses are still available, facts are fresh on witnesses' minds, and evidence is still at the scene. It is very important to take the necessary steps to gather information and to preserve any evidence (i.e. a broken chair or machine part). It is particularly important to gather witness information any time an injury involves a motor vehicle, a machine, or occurs at a location other than the normal workplace. In those cases, it may be possible for York to recover our payments from another party, thus reducing your loss experience.

Actively Communicate With Your Employee

Sustaining a workers' compensation injury can be a stressful event for both the employee and employer. Employees are often worried about their income and job security, in addition to their physical recovery. Employees who must stay home from work can quickly become isolated from their coworkers and managers and can become discouraged about the likelihood of their return to work.

Regular calls and support from an employer can be the most important therapy for an injured worker. It is important the employee feels that his/her employer wants him/her to return to work, and misses him/her while he/she is away.

Actively Communicate With The TPA (York)

Immediately after the injury, it is important that we have the benefit of your investigation of the facts, including witnesses and any possible third parties (i.e. machine manufacturers, other drivers, etc). This information will become the foundation for our own investigation, during which we will look for information to confirm the compensability of the injury, establish the damages, identify any responsible third parties, and begin our efforts to reduce costs as much as possible.

As the claim progresses, it is important that you continue to provide us with any additional information you might learn. This information can include the employee's interest, and his/her performance during the employment. This information will be very helpful in arranging a successful return to work, and to finalizing the claim as quickly and cost-effectively as possible.

Please send York a copy of any of the following documents you may receive:

- Notice of Hearing or Application for Adjudication of claim
- Letters, subpoenas or forms from attorneys or representatives of injured worker
- Letters or forms from any State or Federal Agencies
- Letters, telephone calls or complaints made by injured worker or others
- Any notices or citations received from CAL OSHA
- Any reports or disability slips received from an injured worker's physician
- All inquires for information relative to Workers' Compensation benefits

York will also need to be contacted when:

- An employee is released by the physician to return to work or returns to work.
- The employee goes off work again due to the same injury or illness.
- The employee is not entitled to holiday pay or the school schedule is off-track or on break.
- Any time the employee's work schedule changes.

VI. Return To Work (In-House Program)

Kari Hornberger
CRSIG Return To Work Specialist
4101 Tully Rd., Suite 501
Modesto, CA 95356

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On Call Reporting and Structured Return To Work Program

Background:

Return To Work: Starting October 1st, 2008, districts were requested to work with the Return To Work Specialist for the development of written modified assignments for injured workers. From the latter part of September through the month of October, the Return To Work Specialist meet with each CRSIG member to review the program and how the district wanted to structure the contracts. In addition, The Return To Work Specialist meet with CRSIG designated medical providers to introduce the new program features. *(Please keep in mind that no modified assignment will be initiated without discussions between the Return To Work Specialist, the District Liaison and the employee's supervisor).*

Return To Work Specialist's Role:

- 1) Ensure direct communication with physicians regarding work restrictions for notes and clarification. *(This is geared to ease the follow-up required of school staff currently.)*
- 2) Establish written productive return to work assignments for each restricted employee by communicating directly with the district, supervisor, claims administrator and medical provider. *(The RTW Specialist will meet with each employee and supervisor to execute a written temporary assignment at each junction in the medical recovery.)*
- 3) Follow closely each employee in temporary modified assignments to make sure that measurable medical progress occurs. The standard will be to expect full return to duty within 30 days unless there is a medical justification for an extension. *(This is designed to prevent modified assignments that promote lingering recovery.)*
- 4) Follow up on all medical notes after employee appointments to ensure dissemination of the information to the district liaison, supervisor and claims administrator. Follow up on all medical appointments missed by employees. *(This is geared to ease the follow-up required of school staff currently.)*
- 5) Meet with the employee and medical providers face to face in the cases of lingering recovery. *(This will assist with the facilitation of additional medical care if needed and communicate interest in full recovery to the employee and physician)*

Return to Work Assignment Preference: The order of preference for returning employees to temporary modified assignments will be as follows:

1. Temporary modifications within the employee's current job classification and location
2. Temporary modified assignment within the employee's current job classification, possible change to location
3. Temporary modified assignment outside the employee's job classification.

NOTE: All temporary assignments will be developed and approved based upon management's determination of present work needs and availability of assignments. If no temporary assignment is available, the employee will be placed on temporary disability.

Return To Work Board Policy & Administrative Regulations

While almost all of the CRSIG membership has not implemented a Board Policy and Administrative Regulations for the application of bridge assignments, each have been asked to consider presenting one for adoption. (A sample BP and AR is included in section VI. page 30 & 31)

Duration of Temporary Assignments:

The CRSIG Return To Work Protocols will be used for the application of temporary modified assignments. (Please note the RTW Protocols for specific information.)

Return To Work Protocols

INITIAL MODIFIED DUTY ASSIGNMENTS

- 4 Point contact will be initiated by the RTWS with the employee, supervisor, district liaison
- Initial assignments will be based on the work status report and will not extend beyond 30 days.

ASSIGNMENTS BEYOND 30 DAYS

- 4 Point contact will be initiated by the RTWS with the employee, supervisor and district liaison
- The criteria for extension will include:
 1. Measurable medical progress.
 2. Satisfactory attendance and performance
 3. Scheduled physician follow-up visits at least every 7-10 days
- Modified duty agreement extensions will be granted in weekly increments based upon the type of injury and level of recovery or anticipated recovery at this stage. Every attempt will be made to create assignments that transition along with the employee's medical recovery process.

ASSIGNMENTS BEYOND 60 DAYS

- Prior to consideration of an assignment beyond 60 days, the RTWS will have attended a medical appointment with the employee to review with the medical care provider and employee, the essential job functions of the employee's position/s.
- 5 point contact will be initiated by the RTWS with the employee, supervisor, district liaison, CRSIG Executive Director and claims examiner with an invitation to the Superintendent.
- The criteria for extension will include:
 1. Measurable medical progress.
 2. Satisfactory attendance and performance.
 3. Scheduled physician follow-up visits at least every 7-10 days unless waived.
- Modified duty extensions will be granted in weekly increments based upon the type of injury and level of recovery, anticipated recovery and anticipated permanent and stationary status at this stage.

BEYOND 90 DAYS

- Granted only under extreme or unusual circumstances by the CRSIG Executive Director.

VI. Return To Work

(Department of Industrial Relations
Administrative Rules)

When injured employees become permanent and stationary

TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
ARTICLE 12

RETURN TO WORK

§10116.9. Definitions

(a) "Alternative work" means work (1) offered either by the employer who employed the injured worker at the time of injury, or by another employer where the previous employment was seasonal work, (2) that the employee has the ability to perform, (3) that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and (4) that is located within a reasonable commuting distance of the employee's residence at the time of injury.

(b) "Approved training facility" means a training or skills enhancement facility or institution that meets the requirements of section 10133.58.

(c) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(d) "Employer" means the person or entity that employed the injured employee at the time of injury.

(e) "Essential functions" means job duties considered crucial to the employment position held or desired by the employee. Functions may be considered essential because the position exists to perform the function, the function requires specialized expertise, serious results may occur if the function is not performed, other employees are not available to perform the function or the function occurs at peak periods and the employer cannot reorganize the work flow.

(f) "Insurer" has the same meaning as in Labor Code section 3211.

(g) "Modified Work" means regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(h) "Nontransferable training voucher" means a document provided to an employee that allows the employee to enroll in education-related training or skills enhancement. The document shall include identifying information for the employee and claims administrator, and specific information regarding the value of the voucher pursuant to Labor Code section 4658.5.

(i) "Notice" means a required letter or form generated by the claims administrator and directed to the injured employee.

(j) "Offer of modified or alternative work" means an offer to the injured employee of medically appropriate employment with the date-of-injury employer through the use of Form DWC-AD 10133.53, Notice of Offer of Modified or Alternative Work.

(k) "Parties" means the employee, the claims administrator and their designated representatives, if any.

(l) "Permanent and stationary" means the point in time when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment, based on (1) an opinion from a treating physician, AME, or QME; (2) a judicial finding by a Workers' Compensation Administrative Law Judge, the Workers' Compensation Appeals Board, or a court; or (3) a stipulation that is approved by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

(m) "Permanent partial disability award" means a final award

(n) "Regular Work" means the employee's usual occupation or the position in which the employee was engaged at the time of injury and that offers wages and compensation equivalent to those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(o) "Seasonal Work" means employment as a daily hire, a project hire, or an annual season hire.

(p) "Supplemental job displacement benefit" means an educational retraining or skills enhancement allowance for injured employees whose employers are unable to provide work consistent with the requirements of Labor Code section 4658.6.

(q) "Vocational & return to work counselor (VRTWC)" means a person or entity capable of assisting a person with a disability with development of a return to work strategy and whose regular duties involve the evaluation, counseling and placement of disabled persons. A VRTWC must have at least an evaluations, counseling and placement of disabled adults.

(r) "Work restrictions" means permanent medical limitations on employment activity established by the treating physician, qualified medical examiner or agreed medical examiner.

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 139.48 and 4658.1, Labor Code; Henry v. WCAB(1998) 68 Cal.App.4th 981.

HISTORY

1. Renumbering of former section 10001 to new section 10116.9, including California Code of Regulations, Title 8, Section 10116.9. Definitions for Article 6.5 and 7...amendment of section heading, section and Note, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

§10117. Offer of Work; Adjustment of Permanent Disability Payments

(a) This section shall apply to all injuries occurring on or after January 1, 2005, and to the following employers:

- (1) Insured employers who employed 50 or more employees at the time of the most recent policy inception or renewal date for the insurance policy that was in effect at the time of the employee's injury;
- (2) Self-insured employers who employed 50 or more employees at the time of the most recent filing by the employer of the Self-Insurer's Annual Report that was in effect at the time of the employee's injury; and
- (3) Legally uninsured employers who employed 50 or more employees at the time of injury.

(b) Within 60 calendar days from the date that the condition of an injured employee with permanent partial disability becomes permanent and stationary:

- (1) If an employer does not serve the employee with a notice of offer of regular work, modified work or alternative work for a period of at least 12 months, each payment of permanent partial disability remaining to be paid to the employee from the date of the end of the 60 day period shall be paid in accordance with Labor Code section 4658(d)(1) and increased by 15 percent.
- (2) If an employer serves the employee with a notice of offer of regular work, modified work or alternative work for a period of at least 12 months, and in accordance with the requirements set forth in paragraphs (3) and (4), each payment of permanent partial disability remaining to be paid from the date the offer was served on the employee shall be paid in accordance with Labor Code section 4658(d)(1) and decreased by 15 percent, regardless of whether the employee accepts or rejects the offer.
- (3) The employer shall use Form DWC-AD 10133.53 (Section 10133.53) to offer modified or alternative work, or Form DWC-AD 10118 (Section 10118) to offer regular work. The claims administrator may serve the offer of work on behalf of the employer.
- (4) The regular, alternative, or modified work that is offered by the employer pursuant to paragraph (2) shall be located within a reasonable commuting distance of the employee's residence at the time of the injury, unless the employee waives this condition. This condition shall be deemed to be waived if the employee accepts the regular, modified, or alternative work, and does not object to the location within 20 calendar days of being informed of the

right to object. The condition shall be conclusively deemed to be satisfied if the offered work is at the same location and the same shift as the employment at the time of injury.

(c) If the claims administrator relies upon a permanent and stationary date contained in a medical report prepared by the employee's treating physician, QME, or AME, but there is subsequently a dispute as to an employee's permanent and stationary status, and there has been a notice of offer of work served on the employee in accordance with subdivision (b), the claims administrator may withhold 15% from each payment of permanent partial disability remaining to be paid from the date the notice of offer was served on the employee until there has been a final judicial determination of the date that the employee is permanent and stationary pursuant to Labor Code section 4062.

- (1) Where there is a final judicial determination that the employee is permanent and stationary on a date later than the date relied on by the employer in making its offer of work, the employee shall be reimbursed any amount withheld up to the date a new notice of offer of work is served on the employee pursuant to subdivision (b).
- (2) Where there is a final judicial determination that the employee is not permanent and stationary, the employee shall be reimbursed any amount withheld up to the date of the determination.
- (3) The claims administrator is not required to reimburse permanent partial disability benefit payments that have been withheld pursuant to this subdivision during any period for which the employee is entitled to temporary disability benefit payments.

(d) If the employee's regular work, modified work, or alternative work that has been offered by the employer pursuant to paragraph (1) of subdivision (b) and has been accepted by the employee, is terminated prior to the end of the period for which permanent partial disability benefits are due, the amount of each remaining permanent partial disability payment from the date of the termination shall be paid in accordance with Labor Code section 4658 (d) (1), as though no decrease in payments had been imposed, and increased by 15 percent. An employee who voluntarily terminates his or her regular work, modified work, or alternative work shall not be eligible for the 15 percent increase in permanent partial disability payments pursuant to this subdivision.

(e) Nothing in this section shall prevent the parties from settling or agreeing to commute the permanent disability benefits to which an employee may be entitled. However, if the permanent disability benefits are commuted by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board pursuant to Labor Code section 5100, the commuted sum shall account for any adjustment that would have been required by this section if payment had been made pursuant to Labor Code section 4658.

(f) When the employer offers regular, modified or alternative work to the employee that meets the conditions of this section and subsequently learns that the employee cannot lawfully perform regular, modified or alternative work, the employer is not required to provide the regular, modified or alternative work.

(g) If the employer offers regular, modified, or alternative seasonal work to the employee, the offer shall meet the following requirements:

- (1) the employee was hired for seasonal work prior to injury;
- (2) the offer of regular, modified or alternative seasonal work is of reasonably similar hours and working conditions to the employee's previous employment, and the one year requirement may be satisfied by cumulative periods of seasonal work;
- (3) the work must commence within 12 months of the date of the offer; and
- (4) The offer meets the conditions set forth in this section.

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 139.48 and 4658, Labor Code; Del Taco v. WCAB(2000) 79 Cal.App.4th 1437; Anzelde v. WCAB(1996) 61 Cal. Comp. Cases 1458 (Writ denied); and Henry v. WCAB(1998) 68 Cal.App.4th 981.

HISTORY

1. New article 6.5 (sections 10117-10120) and renumbering of former section 10002 to new section 10117, including amendment of section, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

This position is at the same location and shift as your pre-injury position.

|
—

This position is at a different location than your pre-injury position. The location is:

This position is for a different shift than your pre-injury position. The shift time is _____ — _____
(Start Time) (End Time)

You may contact _____ at _____ concerning this position.
(Name of contact person) Phone Number

You must return the completed form to the employer or claims administrator listed here:

Claims Administrator (To Be Completed By The Employer or Claims Administrator) (All information in this section must be completed)

Name

Claims Mailing Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Representative Phone

This position provides wages and compensation of \$ _____, that are equivalent to or more than
Weekly Wages

the wages and compensation paid to you at the time of your injury.

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.

I, _____
(Name of Claims Administrator)
have obtained the above job offer information from your employer.

|
—

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Case Number _____

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on the form within 20 calendar days of receipt of the offer or it will be deemed that the employee accepted the offer and has waived the right to object to the location or shift.

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance.

You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice. The employee should keep a copy of this form for his or her records.

First Name _____

MI _____

Last Name _____

Date Offer Received _____

MM/DD/YYYY

Claim Number _____

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

I accept this offer of regular work.

I reject this offer of work. Reason

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

1

Offer of Regular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

I accept the offer and waive my right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

I reject this offer of work. Reason

I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

(Signature)

Date _____
MM/DD/YYYY

1

Sample Board Policy for Return To Work

_____ School District

Board Policy

BP _____

Personnel

Temporary Modified/Light-Duty Assignment – OUR Program

The _____ School District is committed to providing a safe workplace for our employees. Preventing work related injuries and illness is our primary goal.

The Governing Board recognizes that when employees suffer work-related injuries, modified or light-duty assignments minimize lost time and may serve to facilitate the transition back to the employee's regular duties or full-time work. Whenever possible, the Superintendent or designee shall offer such employees this kind of temporary assignment.

(cf. 4157.1/4257.1/4357.1 - Work-Related Injuries)

Our early return to work program provides opportunities for an employee who is injured to return to work at full duty whenever possible and alternative assignments when their medical restrictions not allow for a return to full duty. Modified or light-duty assignments will be designed to accommodate medical restrictions specified by the employee's physician. They may include work in the same job classification or a different job classification at the employee's regular salary rate. Only work that is considered productive and meaningful to the school district shall be considered.

Modified or light-duty assignments are intended to address short-term medical restrictions and will normally extend for less than four weeks' duration. These assignments shall not be used as a means to establish new assignments or displace other employees.

All workers will be treated fairly and consistently and are expected to participate and cooperate with the early return to work program.

All managers and supervisors are expected to understand and value the importance of returning an injured worker to work and must provide assistance where appropriate.

Legal Reference:

EDUCATION CODE

44984 Required rules for industrial accident and illness leave

45192 Industrial accident and illness leave for classified employees

Policy _____ SCHOOL DISTRICT

Adopted: _____

Sample Administrative Regulations for Return To Work

_____ School District

Administrative Regulation

AR _____

Personnel

Temporary Modified/Light Duty Assignment – OUR Program

Any employee who suffers a work-related injury shall provide the district with medical verification of his/her physical condition. Unless the treating physician provides a full release from work, the employee may be considered eligible for a temporary modified or light-duty assignment. If the treating physician does not specify work restrictions, the Superintendent or designee may contact the physician to see if modified or light-duty work might be appropriate.

(cf. 4157.1/4257.1/4357.1 - Work-Related Injuries)

The Superintendent or designee shall confer with the employee and his/her supervisor to determine whether the employee can return to his/her regular job with the medical restrictions specified by the physician.

If the employee is not able to return to his/her regular job with restrictions, the Superintendent or designee shall seek a temporary modified or light-duty assignment for the employee. **Employees who are given such assignments shall receive written notification of the assignment.**

Assignments within the employee's classification will be given first preference. Assignments outside the employee's regular work setting and classification will be given only if necessary.

If no temporary modified or light-duty assignment can be found, the employee will be placed on temporary disability, sick leave, or other available leave to the extent available until an appropriate position within the medical restrictions is found, or until the medical restrictions are lifted.

(cf. 4161.11/4361.11 - Industrial Accident/Illness Leave)

(cf. 4261.11 - Industrial Accident/Illness Leave)

If an employee rejects a temporary modified or light-duty assignment, this refusal may provide a basis for terminating temporary disability benefits.

The Superintendent or designee shall monitor all modified and light-duty assignments and may contact the physician for assistance in determining when the employee is ready to resume his/her regular duties.

Regulation _____ SCHOOL DISTRICT

Approved: _____

VII. Penalties

Self-Imposed
Serious & Willful
132A Discrimination

PENALTIES

Self Imposed Penalty:

The law requires that the administrator pay an automatic 10% penalty on payments which are not paid timely. The first payment of temporary disability is due within 14 days of knowledge of a lost time injury. All subsequent checks are to be issued every two weeks on the same day of the week. Any checks issued late shall include an automatic self imposed penalty of 10%.

Serious & Willful Misconduct:

S&W Misconduct can pertain to both the employer and the employee.

Pursuant to Labor Code section 4553, a S&W can be filed against an employer if:

The violation of a safety order caused injury or death to an employee
Or the employer had knowledge of risk of harm and did not correct the problem

Fine: Employee will be awarded 50% increase in benefits including medical and temporary disability

Serious & Willful Misconduct Against an employee:

Pursuant to Labor Code section 4551, a S&W can be filed against an employee if:

The employer/administrator can prove that the employee caused his own injury.

Fine: If found guilty, employee's compensation is reduced by 50% unless the injury caused: Death
Permanent disability > 70%
Injury was caused by safety order
Employee is under 16 yrs of age.

LABOR CODE SECTION 132A-DISCRIMINATION

Examples of a 132a violation: Preventing an employee from filing a claim

Terminating medical benefits while an injured worker is off work
Terminating an injured worker while off work

FINES:

Compensation increased by 50% but not to exceed \$10,000
Employer to pay expenses not to exceed \$250

IF VIOLATION WAS TERMINATION:

The employee will be entitled to reinstatement and reimbursement for lost wages!!

VIII. Certificates of Insurance

How To Obtain A Certificate



Central Region
School Insurance Group

Certificate of Insurance Request Form

Wells Fargo Insurance Services
PO Box 1106
Grass Valley, CA 95945
(530) 271-2722
(888) 298-7213

Attn: Gail Blagg
Email – gail.blagg@wellsfargo.com
OR
(530) 273-6459 fax

Date: _____ District Name: _____

*****CERTIFICATE HOLDER INFO*****

Name: _____

Attn: _____

Address: _____

City: _____ ST _____ Zip _____

Coverages:

- Workers' Comp
- Waiver of Subrogation Wording Required

***PLEASE PROVIDE
COPIES OF INSURANCE REQUIREMENTS, SPECIAL FORMS,
SAMPLE CERTS, AND ANY SPECIAL WORDING.***

Any special instructions insert here:

Please Return by: Mail Fax #: () _____ — _____

Email Attn: _____

Date you need certificate: _____

IX. Industrial Illness, FMLA, CFRA Leave Information

INDUSTRIAL INJURY & ILLNESS LEAVE

Ed. Code Benefits &
Other Leaves to Consider

EDUCATION CODE BENEFITS:

Industrial Illness & Injury Leave

- ⇒ Employees are entitled to 60 working days of full pay (cumulative per claim)
- ⇒ Employee receives 60 days of Ed. Code benefits for each new injury
- ⇒ Note: Bargaining language may enhance the leave benefit
- ⇒ After 60 days, the employee then uses current sick leave, then accumulated sick leave
- ⇒ Classified employees must also use up any vacation pay ⇒ Certificated then goes on difference pay

Paying Benefits

- ⇒ Steps to establish the payment of benefits:
 1. Establish temporary disability rate -
Is the employee pay based upon 9/12, 10/12, 12/12 or 9/9, 9/10?
 2. Establish employee's work status – Certificated, Classified, Substitute
 3. Establish type of payment – Continue full pay, check to employee (eg. Subs.)

39 Month Rehire List

- ⇒ Once the difference pay has stopped, the employee is placed on the 39 month rehire list
- ⇒ Problem Areas:
 - 132a Discrimination Law Suits – Always gain legal counsel before terminating injured employee benefits
- ⇒ Other Areas to Note:
 - Industrial leave SHALL commence on the 1st day of absence
 - Employees receiving TTD must remain within the State of California unless the school district authorizes travel outside the State

OTHER LEAVES:

- ⇒ FMLA (Family Medical Leave Act) Leave – 12 weeks in 12 month period
Should run consecutively with Industrial Injury/Illness Leave
- ⇒ CFRA (California Family Rights Act) Leave – 12 weeks in 12 month period
Should run consecutively with Industrial Injury/Illness Leave

X. OTHER FORMS

Employers Report – 5020

Employee's Claim Form – DWC-1

Supervisors Report of Injury/Illness

Medical Authorization Form

Log For Dispensing Employee Claim Forms

Notice of Employee Death

Claim Retraction

*Facts About Workers' Compensation Pamphlet

*MPN Pamphlet

(*Pamphlets are located in front pocket of binder)

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in triplicate (type if possible) Mail two copies to:		OSHA CASE NO.
				FATALITY <input type="checkbox"/>
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.		California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.		
EMPLOYER	1. FIRM NAME	1a. Policy Number	Please do not use this column	
	2. MAILING ADDRESS: (Number, Street, City, Zip)	2a. Phone Number	CASE NUMBER	
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)	3a. Location Code	OWNERSHIP	
	4. NATURE OF BUSINESS, e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.	5. State unemployment insurance acct. no.		
	6. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____			INDUSTRY
7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM	9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. DATE LAST WORKED (mm/dd/yy)	13. DATE RETURNED TO WORK (mm/dd/yy)	14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>	
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)	
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning				AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No	
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.		23. Other Workers injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAILY HOURS
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold				DAYS PER WEEK
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.				WEEKLY HOURS
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY				WEEKLY WAGE
27. Name and address of physician (number, street, city, zip)				COUNTY
28. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes then, name and address of hospital (number, street, city, zip)		27a. Phone Number		NATURE OF INJURY
		28a. Phone Number		PART OF BODY
		29. Employee treated in emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		SOURCE
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) & 14300.36(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.36(b)(2)(E)2.				
30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	
33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER		EVENT
34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		34. DATE OF HIRE (mm/dd/yy)	
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours		37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal	37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED	
38. GROSS WAGES/SALARY \$ _____ per _____		38. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.?) <input type="checkbox"/> Yes <input type="checkbox"/> No		EXTENT OF INJURY
Completed By (type or print)		Signature & Title		Date (mm/dd/yy)
<p>* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.36), 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.</p>				

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to \$10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-Primary Treating Physician PTP es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al PTP que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas diferentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por \$10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesiones por un periodo limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



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

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

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

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

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

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

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

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

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

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitos, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

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

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Código Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores (*Division of Workers' Compensation - DWC*) o puede escuchar información grabada, así como una lista de oficinas locales llamando al (800) 736-7401. Ud. también puede consultar con la página Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California (*State Bar*) al (415) 538-2120, ó consulte con la página Web en www.californiaspecialist.org.



WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above Empleado—complete esta sección y note la notación arriba.

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____
6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

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

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

Claims Administrator/Administrador de Reclamos Temporary Receipt/Recibo del Empleado



SUPERVISOR'S REPORT OF EMPLOYEE INJURY/ILLNESS

Employee Name:		
Occupation:		
Work Site:		
Date of Injury:		
Time of Injury:		
Accident Location:		
Type of Injury:		
Date Reported:		
Time Reported:		
Medical Facility Employee Was Sent To:		
Did worker leave work?	YES	NO
Did worker return to work?	YES	NO
Describe how the accident occurred		
Name of Witnesses:		
What steps have been taken to prevent similar accidents?		
Supervisor Signature		Date:
Date sent to District Office:		

Please send this report to: _____



MEDICAL AUTHORIZATION FORM

To: York Insurance Services Group, Inc.
P.O. Box 619079
Roseville, CA 95661-9058

I, _____ hereby authorize the following medical providers (medical provider is defined as any acupuncturist, clinic, chiropractor, physical therapy provider, primary physician, or specialist who has administered medical treatment to me) to disclose their entire medical file and any other protected health information concerning me to YORK INSURANCE SERVICES GROUP, INC. and its agents, employees and representatives. The protected health information to be disclosed includes medical records; doctors notes; laboratory records/reports; diagnostic test reports/films; photographs; bill/statement of charges; and, all documentation pertaining to history, examination, diagnosis, condition, etiology, prognosis, treatment and care.

Faculty/Physician Name/s				
Address				
Phone Number				
First Treatment Date				
Last Treatment Date				

This authorization also includes disclosure of information on the diagnosis and treatment of:

	Yes	No
Mental illness including psychiatric/psychological treatment	___	___
Alcohol, drugs and tobacco	___	___
HIV infection and sexually transmitted diseases	___	___

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction except those outlined above. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508©(1)(IV) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to YORK INSURANCE SERVICES GROUP, INC. or by sending a written revocation directly to My Providers. I further understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, YORK INSURANCE SERVICES GROUP, INC. agrees to protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Provider may not refuse to provide treatment or payment for health care because I refused to sign this Authorization. I acknowledge that I have received a copy of this Authorization.

Signature

Print Name

Date

Date of Birth

Social Security Number

This authorization complies with HIPAA Privacy Rule

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FORWARD TO

P.O. BOX 422400
SAN FRANCISCO CA 94142

NOTICE OF EMPLOYEE DEATH

EACH EMPLOYER SHALL NOTIFY THE ADMINISTRATIVE DIRECTOR OF THE DEATH OF EVERY EMPLOYEE REGARDLESS OF THE CAUSE OF DEATH EXCEPT WHERE THE EMPLOYER HAS ACTUAL KNOWLEDGE OR NOTICE THAT THE DECEASED EMPLOYEE LEFT A SURVIVING MINOR CHILD (TITLE 8, CHAPTER 4.5, SECTION 9900).

DECEASED EMPLOYEE:

NAME: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

LAST KNOWN ADDRESS: _____

NAME, RELATIONSHIP AND LAST KNOWN ADDRESS OF NEXT OF KIN: _____

JOB TITLE AND NATURE OF DUTIES: _____

DATE, TIME AND PLACE OF ACCIDENT: _____

DATE, TIME AND PLACE OF DEATH: _____

CIRCUMSTANCES OF DEATH (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN DEATH. TELL WHAT HAPPENED. USE ADDITIONAL SHEET IF NECESSARY):

CAUSE OF DEATH (ATTACH COPY OF DEATH CERTIFICATE OR CORONER'S REPORT):

HAVE ANY WORKERS' COMPENSATION DEATH BENEFITS BEEN PROVIDED IN CONNECTION WITH THIS DEATH? ____ YES ____ NO

IF YES, TO WHOM: _____

ATTACH A COPY OF THE FORM 5020, "EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS," IF ONE WAS FILED.

PLEASE NOTE:

IF THE DEATH IS WORK-RELATED, THE EMPLOYER ALSO IS REQUIRED TO REPORT THE DEATH TO HIS OR HER WORKERS' COMPENSATION INSURANCE CARRIER AND TO THE NEAREST OFFICE OF THE DIVISION OF INDUSTRIAL SAFETY IMMEDIATELY BY TELEPHONE OR TELEGRAPH. AN EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS SHOULD ALSO BE FILED WITH THE WORKERS' COMPENSATION INSURANCE CARRIER.

() INSURED () SELF-INSURED () LEGALLY UNINSURED

EMPLOYER: _____ INSURANCE CARRIER
OR ADJUSTING AGENT: _____

STREET: _____ STREET: _____

CITY/STATE: _____ ZIP: _____ CITY/STATE: _____ ZIP: _____

TELEPHONE: _____ TELEPHONE: _____
(INCLUDE AREA CODE) (INCLUDE AREA CODE)

BY: _____

TITLE: _____

DATE: _____

CLAIM RETRACTION

My name is _____, I live at _____.
(Name) (Address)
My telephone number is _____, My date of birth is _____.
(Telephone #) (Date of Birth)
I am _____ years old. My social security number is _____.
(Age)
I work as a _____ in _____, California.
(Occupation) (City)

I am providing this affidavit of my own free will. I have been given a copy of the DWC-1 and Notice of Potential Eligibility. I have reviewed the notice and all the potential benefits provided by workers' compensation and understand the potential benefits. I am not interested in pursuing a claim for workers' compensation benefits against the _____ School District administered by York Insurance Services Group, Inc. I request my claim for workers' compensation benefits dated _____ be withdrawn. I understand that York Insurance Services Group, Inc. will issue a denial letter, because I choose not to participate in the discovery process of this claim.

I declare under the laws of the State of California that the above statement is true and correct to the best of my knowledge.

EXECUTED ON THE _____ DAY OF _____, _____ AT _____, CA.
(Month) (Year) (City)

X _____
(Claimant) (Date)

X _____
(Witness) (Date)