CITY OF CHICO

Administrative Procedure and Policy Manual

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WORKERS' COMPENSATION CLAIM ADMINISTRATION PROCEDURES</td><td>Number: 13-23
Effective Date: 01/01/2021</td></tr>
<tr><td colspan="2">Department(s) Affected: All Departments</td><td>Supersedes: 13-23 Dated 06/16/78, 01/1/93, 03/16/10, 08/06/12</td></tr>
<tr><td>Authority: Resolution No. 207 77-78; Section 2.12.010 Chico Municipal Code</td><td colspan="2">File Reference: D-13
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I. PURPOSE:

To provide a uniform policy regarding the processing of Workers' Compensation claims and utilization of leave for disabilities arising out of and in the course of employment.

II. POLICY

A. General Provisions

It is the policy of the City to provide any employee who is injured or becomes ill as a result of activities arising out of and in the course of his/her employment the full benefits to which he/she is entitled under Workers' Compensation laws of the State of California.

B. Temporary Disability Payments

1. Whenever any permanent classified, management, or Council appointed employee is temporarily disabled by injury or illness arising out of and in the course of employment or duties, the employee shall become entitled, regardless of the employee's period of service, to a leave of absence while so disabled without loss of pay in lieu of temporary disability payments, if any, which would be payable under the Workers' Compensation laws of the State of California for the period of such disability, but not to exceed one year, or until such earlier date as the employee is separated from service.

2. During the period of said disability, the City shall not charge such leave against the employee's accrued sick leave, vacation, other leave balances or retirement. The employee shall continue to accrue all benefits as though he or she were on the job. However, employees may not use leave balances to extend benefits which may be obtained under this policy, and are not eligible to receive donated sick leave hours for leave due to a workers' compensation claim.

3. Hourly and contractual service employees of the City will receive temporary disability benefits as provided by the Workers' Compensation laws of the State of California.

III. PROCEDURE

A. Reporting of Injuries/Illnesses

1. Any employee who is injured or becomes ill because of his/her job must report that injury or illness immediately to his/her immediate supervisor, or as soon as he/she becomes aware of it. If the immediate supervisor is not available, the injury must be reported to the next level of supervision.

2. It is the responsibility of the supervisor to provide the employee with a "Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility", attached as Exhibit "1", within 24 hours of the time that the employee reports the injury to his/her supervisor or another employee, or after the supervisor receives knowledge of the injury or illness. This form is provided by the State of California Department of Industrial Relations, Division of Workers' Compensation. This form may be mailed to the employee's home or provided to a representative of the employee if the employee is not available to receive the form.

3. The supervisor must complete the "Employer" section of the form, beginning with item 9 (Name of Employer), excluding item 13 (Date Employer received claim form), and have the employee sign at item 8

(Signature of Employee), acknowledging that he/she has been provided with the DWC -1 Form. The supervisor will retain the top (white) copy of the form, which will be retained in the Department office until the DWC - 1 Form is returned by the employee, at which time it will be forwarded to the Human Resources & Risk Management Office, as noted in Section III.A.5.

4. The employee may choose to return the DWC - 1 Form to the supervisor to initiate a claim. If the employee does not feel that his/her injury or illness should be considered as a Workers' Compensation claim, the employee is not required to return the form.

5. If the employee returns the form to the supervisor, the supervisor must add the date to item 13 (Date employer received claim form) and provide the employee with a copy of the form. Remaining copies of the form, including the original copy, must be immediately forwarded to the Human Resources & Risk Management Office for opening of a claim.

6. The supervisor is responsible for the completion of the "Incident Report", attached as Exhibit "2", for every instance where an employee reports a *potential* work related injury or illness. A supervisor must also prepare such a report if he/she feels an injury has occurred, even if the employee has not returned the DWC - 1 Form. Full information should be entered in every section of the Incident Report. The description of the injury and statements of witnesses are especially important. Supervisors should document the investigation of the cause of the injury on this form and any recommended corrective action that is necessary.

7. The Incident Report and the completed DWC - 1 form (if returned by the employee), must be completed by the Department as soon as possible following the reported injury, but no later than five days following the reported injury, and immediately forwarded to the Human Resources & Risk Management Office for processing.

B. Medical Treatment for Work Related Injuries and Illnesses

1. Employees who are injured on the job shall be immediately provided with first aid care as indicated by the type of injury or illness suffered. Those employees who require treatment beyond job site first aid shall receive such care from the City's designated physician. The name, location, and hours of operation for the City's Workers Compensation physician shall be available at the Human Resources & Risk Management Office. If the injury requiring treatment beyond first aid occurs outside those hours and requires immediate treatment or is life threatening, the employee should receive such care at a hospital emergency room.

2. An employee may designate a personal physician, who has treated him/her in the past and has a record of his/her medical history, to provide physician's care when needed for Workers' Compensation injuries, in lieu of utilizing the City's Workers' Compensation physician. Pursuant to State Workers' Compensation laws, that provider must be a Medical Doctor and cannot be a Chiropractor or other medical provider. Employees who wish to designate a personal physician must complete the "Pre-Injury Personal Physician Pre-Designation for Work Related Injuries" form, attached as Exhibit "3". Such designation must have occurred and be on file with the Human Resources and Risk Management Office prior to the injury for which the employee is seeking treatment. Under the provisions of State Workers' Compensation law, injured employees may choose to change treating physicians only one time in the course of treatment for their injury or illness.

3. Any employee filing a workers' compensation claim as a result of a job-related injury or illness shall be required to provide his/her supervisor a City of Chico "Physician Letter", attached as Exhibit "4." A Physician Letter will be required each time the employee misses any work time, has work restrictions/limitations that require accommodation, receives follow-up care, or is released to return to work following a work related injury or illness. A copy of this form must be filed with the employee's supervisor and Human Resources & Risk Management Office immediately after receipt and prior to returning to work.

C. Payment of Temporary Disability

1. An employee who is unable to immediately continue his/her work because of a work related injury will be considered to be actively working during the time that he/she is receiving first aid or care from a physician, up to the full length of his/her regular work day. Such time should be reported as regular work hours.

2. An employee who files a Workers' Compensation claim shall initially have any time lost charged to sick leave balances, or leave without pay if he/she does not have adequate sick leave, pending acceptance of the

claim by the City's Workers' Compensation claims administrator. An employee without available sick leave may authorize use of his/her accrued vacation. Timely completion of the Incident Report will assist in expediting the acceptance of the employee's injury as work related.

3. As soon as the City has received information that a claim has been accepted as work related, the Human Resources & Risk Management Office will notify the Department of the acceptance and that any time lost by the employee as a result of the injury should be converted to a period of temporary disability. Any time lost by a permanent employee as a result of the injury will be charged to Workers' Compensation Leave. If employee time cards were processed for payment which debited employee's sick, vacation, or other leave balance to cover leaves of absence that have subsequently been accepted as periods of temporary disability, that time will be re-credited to the employee's leave balance by the Finance Office. Eligible employees will continue to receive their regular rate of pay for a period not to exceed one year cumulatively, per injury. If at the end of the one year period, the employee is unable to return to light, modified or full duty, and the City is unable to permanently accommodate, the employee will be separated from City service.

   If the claim is not accepted as work related, the employee's leave time will remain charged to originally identified leave balances or leave without pay, and the employee may submit treatment costs to his/her health insurance.

4. Employees are encouraged to obtain any needed medical follow-up care at times during which they are not scheduled to work. If a permanent employee is unable to schedule appointments outside of his/her regular work day, he/she must provide documentation of the appointment to the Department, and such time may be charged to Workers' Compensation leave as a period of temporary disability. The employee may also be scheduled for follow-up evaluation or care by the City's Workers' Compensation physician.

5. Hourly and contractual service employees are not eligible for temporary disability for periods of less than one day. Any temporary disability payments for hourly and contractual service employees will be made directly to the employee from the City's Workers' Compensation administrator, as provided by the Workers' Compensation laws of the State of California.

D. Light or Modified Duty

Based on the Physician Letter, required pursuant to B.4, departments are encouraged to accommodate limitations set by the treating physician and allow employees to return to light or modified duty as soon as they are able. Such light or modified duty assignments need not be in the same function or the same Department in which the employee is normally assigned but may take advantage of skills that the employee has. The employee will continue to receive his/her regular rate of pay for such light or modified duty assignments for a period not to exceed 180 calendar days cumulatively, per injury. If the employee is unable to return to full duty, after exhausting the one year leave of absence without loss of pay and 180 days of light duty, and the City is unable to permanently accommodate, the employee will be separated from City service.

E. Reasonable Accommodation

The City will engage in a timely and good faith interactive process with the employee, as required by FEHA and the ADA, in order to make a reasonable effort to identify appropriate accommodation. Through this process, the employee may be considered for available positions within the City, for which they are qualified, and which do not exceed their limitations. If the City is unable to accommodate, the employee will be separated from City service.

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

Formulario de Reclamo de Compensación para 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. For injuries occurring on or after 1/1/04, 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. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. 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 an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same 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, you will receive temporary disability payments. 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.

Si Ud. se lesiona o se enferma, ya sea física 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 para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para 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/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete 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/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) 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(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con toda la responsabilidad para dar el tratamiento para 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 pre-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 especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

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

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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 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.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefit (SJDB): If you do not return 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. SJDB is a benefit for injuries occurring on or after 1/1/04.

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, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC web site at **www.dir.ca.gov.** Link to Workers' Compensation.

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**.

impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado(a) de 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/la administrador(a) 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 extenderse o no temporalmente, 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.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne 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 requisitios, el administrador(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

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 vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de 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 al Trabajador *(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 ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org**.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included 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 Division de Compensación al Trabajador al **(800) 736-7401** para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios 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 occurió el accidente.* ____________
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* ____________
7. Social Security Number. *Número de Seguro Social del Empleado.* ____________
8. 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 adminstradora de seguros.* ____________
15. Insurance Policy Number. *El número de la póliza de Seguro.* ____________
16. Signature of employer representative. *Firma del representante del empleador.* ____________
17. Title. *Título.* ____________ 18. Telephone. *Teléfono.* ____________

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

CITY OF CHICO – INCIDENT REPORT

❑ Declined Medical Treatment ❑ Requested/Received Medical Treatment

EMPLOYEE PORTION

Employee Name:	**Job Title:**	**Department:**	**Employee #:**

Home Address:	**Phone Number:**

Date of Birth:	**Gender:** ❑ Male ❑ Female	**Date of Hire:**	**Shift, Work Days, Hours Per Day:**	**Shift Start Time:** am/pm
Incident Date:	**Incident Time:** am/pm	**Location of Incident:**		
Date Reported:	**Reported To (Name, Job Title):**			**Date Claim Form Provided:**

Incident Classification: (select all that apply) ❑ Fall ❑ Lifting ❑ Exposure ❑ Caught In/Between ❑ Trip/Slip ❑ Struck by object ❑ Bite/sting ❑ Training ❑ Vehicle accident, with injury ❑ Vehicle accident, no injury ❑ Cut, puncture, scrape ❑ Other

Body Part Injured (e.g., right wrist, left knee, etc.):	**How Injury Occurred** (struck by…, fell from…, etc.):

Was safety equipment provided? ❑ No ❑ Yes ❑ DNA	**Was safety equipment utilized?** ❑ No ❑ Yes ❑ DNA	**Equipment/materials Employee was using when incident occurred:**

Did Employee leave shift to go home? ❑ No ❑ Yes	**Unable to work for at least one full day?** ❑ No ❑ Yes	**Date last worked:**	**Date returned to work:**	**Still off work?** ❑ No ❑ Yes

Were other Employees injured? ❑ No ❑ Yes If yes, name(s):	**Were there witnesses to the incident?** ❑ No ❑ Yes If yes, name(s):

Describe any <u>previous</u> conditions/injuries to body part currently injured:

Employee Statement of Incident. This section should be filled out by the Employee and include as much detail as possible, such as activity being performed, objects carried, equipment used, hazardous conditions, etc. Attach additional sheets if necessary:

Recommendation on how to prevent this accident from recurring:

Please check one:

❑ I understand that I **<u>am not</u>** filing a Workers' Compensation claim at this time. I choose not to complete the Form DWC-1, "Employee's Claim for Workers' Compensation Benefits" at this time. If I am in need of medical treatment in the future related to this incident, I will immediately inform my Supervisor and complete the Form DWC-1.

❑ I understand that I **<u>am</u>** filing a Workers' Compensation claim at this time. I am also aware that I must also immediately inform my Supervisor and complete the Form DWC-1.

Employee Acknowledgement: The above information is true and correct to the best of my knowledge.

Employee's Signature:	**Date:**

SUPERVISOR'S PORTION

Medical Treatment: ❑ Employee requires/requests medical treatment from a physician.
❑ Employee declined medical treatment or only received minor First Aid care. (Please complete page 2)

Question		
Do you agree with the Employee Statement of Incident?	❑ No	❑ Yes
Could the injury have been prevented?	❑ No	❑ Yes
If yes, has corrective action been taken or Employee been counseled on prevention of further occurrence?	❑ No	❑ Yes
Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures?	❑ No	❑ Yes
Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures?	❑ No	❑ Yes
Had any safety hazards that contributed to this incident been previously reported?	❑ No	❑ Yes
Did employee promptly report the injury/illness?	❑ No	❑ Yes

Please indicate what contributed to the injury or illness (check all that apply):

❑ Improper instruction	❑ Unsafe arrangement or process	❑ Lack of training or skill	❑ Unsafe position or posture
❑ Poor ventilation	❑ Operating without authority	❑ Improper dress	❑ Distraction/Horseplay
❑ Improper maintenance	❑ Physical or mental impairment	❑ Unsafe/defective equipment	❑ Unguarded hazard
❑ Improper use of equipment	❑ Improper lifting technique	❑ Failure to wear/improper use of protective equipment	
❑ Inoperative safety device	❑ Poor housekeeping	❑ Other ______________________	

Supervisor comments regarding incident (***<u>Required</u>***: Comments are forwarded to the City-Wide Safety Committee for review):

Supervisor Name:	**Title:**	**Telephone:**

Signature:	**Date:**

CITY OF CHICO
DECLINATION OF MEDICAL TREATMENT

This form should be completed ONLY if the Employee DECLINES medical treatment. If the Employee visits their pre-designated physician or the City's designated medical facility the "Employee's Claim for Workers' Compensation Benefits" (Form DWC-1) must also be completed.

EMPLOYEE: Check all that apply.

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

OR

In my opinion, I have received sufficient First Aid care in the form of:

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

I am fully capable of performing my Usual and Customary position. At this time, I decline medical care. If I need medical care related to this incident in the future, I will notify my Supervisor immediately and complete the Form DWC-1.

Employee Name: ______________________________ Job Title: ______________________________

Employee Signature: ______________________________ Date: ______________________________

SUPERVISOR:

Supervisor Name: ______________________________ Job Title: ______________________________

Supervisor Signature: ______________________________ Date: ______________________________

Note: California Labor Code Section 5401(a) defines a First Aid injury as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which does not ordinarily require medical care" and states that any injury that "results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid" must be filed as a claim. All of the treatments detailed above fall under the First Aid category; therefore, unless further treatment is necessary, a workers' compensation claim does not need to be filed.

WORKERS COMPENSATION PRE-DESIGNATION OF PHYSICIAN

Employee Name (please print): ______________________________

Employee's Address: ______________________________

Pre-designation of Personal Physician

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

You may use this form, a form provided by your employer or provide all the information in writing to notify your employer if you wish to have your personal medical doctor or a doctor osteopathic medicine treat you for a work related injury/illness and the above requirements are met.

Employee: Complete this section

To: **City of Chico**. If I have a work-related injury or illness, I choose to be treated by:

Name of doctor (M.D., D.O., or medical group): ______________________________

Street address, city, state, zip: ______________________________

Telephone number: ______________________________

Employee Signature: ______________________________ Date: ______________

Note to Employee: Unless you agree in writing, neither your employer nor York may contact your personal physician to confirm a pre-designation. If your physician does not sign this form, other documentation that they agreed to be pre-designated prior to the injury will be required. If you agree, your employer or York may contact your personal physician to confirm this pre-designation, sign and date below:

Employee Signature: ______________________________ Date: ______________

Physician: I agree to this Pre-designation:

Physician or Designated Employee of the Physician: ______________________________ Date: ______________

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).
(Optional DWC Form 9783 July 1, 2014)

Pre-designation of Chiropractic or Personal Acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network (MPN), you may be able to change your treating physician to your personal chiropractor (D.C.) or acupuncturist (L.AC.) following a work-related injury/illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal D.C. or L.AC. in writing prior to the injury/illness. York generally has the right to select your treating physician within the first 30 days after your employer knows of your injury/illness. After your employer or York has initiated your treatment with another physician during this period, you may then, upon request, have your treatment transferred to your personal D.C. or L.AC. You may use this form to notify your employer of your personal D.C. or L.AC., or your employer may have their own form. The D.C. or L.AC. must be your regular D.C. or L.AC. who has directed your treatment and retains your chiropractic records and history. If your employer has an MPN, you may only switch to a D.C. or L.AC. within the MPN. A chiropractor cannot be your treating physician after 24 visits. If you still require medical treatment thereafter, you will have to select a physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

Name of chiropractor or acupuncturist (D.C., L.A.C.): ______________________________

Street address, city, state, zip: ______________________________

Telephone number: ______________________________

Employee Signature: ______________________________ Date: ______________

Title 8, California Code of Regulations, section 9783.1. (Optional DWC Form 9783.1 Effective date July 1, 2014)

Revised Date: 07/01/2014

CITY OF CHICO – PHYSICIAN LETTER

❑ Non-Industrial ❑ Industrial

Employees of the City of Chico are required to submit a letter to his/her department following each doctor's visit in workers compensation cases and in accordance with the time frame specified in the Administrative Procedure & Policy relating to Sick Leave Accrual Schedules for personal illness or injury (AP&P 13-21).

EMPLOYEE/INJURY INFORMATION	
Employee Name:	Date of Injury:
Date of Exam:	Date of Next Appointment:
Prognosis:	Referred To:
Physical Therapy Ordered: ❑ No ❑ Yes	Surgery Scheduled: ❑ No ❑ Yes, Date:

WORK STATUS	
❑ Released to full duty with no restrictions. *Effective Date:*	
❑ Restricted/modified duty. *Effective Date:*	*Estimated return to full duty:*

WORK RESTRICTIONS/FUNCTIONAL CAPACITY

Maximum hours employee can perform each activity per day

Activity	No Restriction	6 Hours	4 Hours	2 Hours	1 Hour	Precluded	Comments
Sitting							
Standing							
Walking							
Squatting/Kneeling							
Crawling							
Laying on Back/Stomach							
Bending							
Twisting							
Reaching/Pushing/Pulling							R / L / Bilateral (Circle)
Grasping							
Fine Manipulation							
Keyboard Use/Typing							
Lifting							May not lift at a height of waist / shoulder / overhead (circle) more than ______ lbs.
Carrying							May not carry at a height of waist / shoulder / overhead (circle) more than ______ lbs.
Driving							
Commercial Driving							

Question	Yes	No
Does employee need periodic rest breaks?	❑ Yes	❑ No
Can employee have contact with the public?	❑ Yes	❑ No
Is employee on any medication that affects work ability (driving, operating machinery)?	❑ Yes	❑ No
Can employee work in extreme temperatures?	❑ Yes	❑ No
Can employee work at extreme heights?	❑ Yes	❑ No
Has the employee's job description been reviewed?	❑ Yes	❑ No

Additional restrictions/comments:

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my knowledge and belief that I have not violated California Labor Code Section 139.3

Physician's Name:	Facility Phone Number:	Facility Fax Number:
Facility Address:		
Physician Signature:		Date: