DO YOU KNOW WHAT TO DO IF AN EMPLOYEE IS INJURED AT WORK?

- Direct Employee to immediately call Company Nurse at 1-877-854-6877 available 24 hours)

- Immediately provide Industrial Injury Packet to Employee. Be sure to put date on when DWC-1 is given to Employee and when it was returned. Return original to Maria Cabrera in Business Services for review and signature. Copy will be provided to Employee upon full execution.

- If Company Nurse directs Employee to Urgent Care, put date on Treatment Authorization Form, copy it and give original to Employee to give to Urgent Care. Send "Copy" to Maria Cabrera in Business Services. These are pre-signed to expedite authorization, so be sure to <u>give out only if directed to Urgent Care</u>.

- If Employee declines medical treatment, be sure they complete the "Declined Medical Treatment" form. Give Employee a copy, and send original to Maria Cabrera in Business Services.

- Have Supervisor complete Supervisor's Report of Injury. Keep copy and send original to Maria Cabrera in Business Services.

- Take photos of area as soon as possible if needed, especially if it's something that caused the injury and needs to be fixed (i.e., uneven ground, water on the floor, broken chair, etc.) Call Maria Cabrera if not sure work order or photos are needed.

- Send all documents Employee gives you to Maria Cabrera in Business Services. Call or email with any questions.

Reporting an injury immediately helps prevent delays in treatment/benefits and increases likelihood of an early return to work for your employee.

IN CASE OF WORKPLACE INJURY:

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE

Injury Hotline

1-877-854-6877

AVAILABLE 24 HOURS A DAY

1. Injured worker notifies supervisor.
   Empleado lesionado notifica a su supervisor.

2. Supervisor / Injured worker immediately calls injury hotline.
   Supervisor / Empleado lesionado llama inmediatamente a la línea de enfermeros/as.

3. Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.
   Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizar el tratamiento médico adecuado.

GROUP CODE (CÓDIGO DEL GRUPO)

WSGAB

Notice to Employer/Supervisor:

Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site when possible.

Visit us online: www.CompanyNurse.com

Temple City Unified School District

EMPLOYEE'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Call Company Nurse 1-877-854-6877

Please complete and return this form to your supervisor IMMEDIATELY. Contact Maria Cabrera in the Business Office at (626) 548-5119 or mcabrera@tcusd.net if you have any questions.

PLEASE PRINT CLEARLY

DATE OF INJURY:	TIME OF INJURY:	TIME YOU BEGAN WORK:	ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
ADDRESS WHERE INJURY/ILLNESS OCCURRED:			
SUPERVISOR'S NAME:	WHO DID YOU REPORT THE INCIDENT TO?	DID YOU GET A CLAIM FORM (DWC-1)? ☐ YES ☐ NO	
LIST SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED:			
HAVE YOU EVER SUSTAINED AN INJURY/ILLNESS TO THIS BODY PART BEFORE NOW? ☐ NO ☐ YES WHEN? WHERE?			
DEPARTMENT WHERE INJURY/ILLNESS OR EXPOSURE OCCURRED:			
EQUIPMENT, MATERIALS OR CHEMICALS YOU WERE USING WHEN INCIDENT OR EXPOSURE OCCURRED:			
SPECIFIC ACTIVITY YOU WERE PERFORMING WHEN INCIDENT/EXPOSURE OCCURRED (EXPLAIN SEQUENCE OF EVENTS IN DETAIL):			
DESCRIBE SEQUENCE OF EVENTS LEADING TO INJURY:			
LIST NAMES, ADDRESSES, AND PHONE NUMBERS OF PERSON(S) PRESENT AT TIME OF INCIDENT: Name: Address: Phone: ( ) Name: Address: Phone: ( )			
DO YOU FEEL SOMETHING COULD HAVE BEEN DONE TO PREVENT THIS INCIDENT? ☐ NO ☐ YES IF "YES", PLEASE EXPLAIN:			

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
HOME PHONE: ( )	CELL PHONE: ( )	DATE OF BIRTH:
HOME ADDRESS:	CITY	ZIP:

SOCIAL SECURITY NO:	JOB TITLE:
DATE OF HIRE	WORK SCHEDULE (HOURS PER DAY) M ____ T ____ W____ Th ____ F ____ Sat ____ Sun _____
TODAY'S DATE:	I CERTIFY THAT THE FOREGOING IS TRUE AND CORRECT. EMPLOYEE SIGNATURE:

Original: Business Office
cc: Site/Department File

(Rev 2/16)

TEMPLE CITY UNIFIED SCHOOL DISTRICT
Declined Medical Treatment

NAME OF INJURED EMPLOYEE:	DATE OF INCIDENT:	DATE REPORTED:
SCHOOL SITE OR LOCATION:	**POSITION / REGULAR DEPARTMENT:**	

DETAILS OF INCIDENT:

☐ **My signature below confirms that <u>I am not</u> experiencing any signs or symptoms resulting from the industrial accident indicated above. Medical treatment has been offered but I further decline any medical evaluation or treatment as a result of this job-related accident.**

☐ **My signature below confirms that <u>I am</u> experiencing signs or symptoms resulting from the industrial accident indicated above. Medical treatment has been offered but I further decline any medical evaluation or treatment as a result of this job-related accident.**

If the need for medical treatment arises as a result of this injury, I have been instructed to inform my supervisor and to immediately contact Maria Cabrera in the Business Office at (626) 548-5119. If I elect to seek medical treatment without advising my employer, or without obtaining authorization from my employer, I understand I may be responsible for the total cost of said treatment.

EMPLOYEE SIGNATURE:	DATE:

This document <u>is not</u> a waiver of workers' compensation benefits as stated by Labor Code 5405(a), where no benefits have been provided, the injured employee has a maximum period of one year from the date of injury to obtain medical treatment and benefits.

ORIGINAL - Business Services COPY 1 - Employee COPY 2 - Site or Dept. Office

PRINT CLEAR

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

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

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

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

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

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

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

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

10. Name of employer. *Nombre del empleador.* **TEMPLE CITY UNIFIED SCHOOL DISTRICT**
11. Address. *Dirección.* **9700 LAS TUNAS DRIVE, TEMPLE CITY, CA 91780**
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
Sedgwick, PO Box 14852, Lexington, KY 40512; John Anderson, (951) 231-6834, john.anderson@sedgwick.com
16. Insurance Policy Number. *El número de la póliza de Seguro.*_____
17. Signature of employer representative. *Firma del representante del empleador.* _____ Maria Cabrera mcabrera@tcusd.net
18. Title. *Título.* **Executive Assistant-Business Svcs.** 19. Telephone. *Teléfono.* **(626) 548-5119**

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*

Supervisor's Report of Injury or Illness

1. Employee's name:

2. Job title or position:

3. Name of employer:

4. Name of supervisor:

5. Department:

6. Date and time of event:

7. Location/address where event occurred:

7a. On employer's property? ☐ Yes ☐ No

8. Date of knowledge of event:

9. Name and title of person to whom the even was reported:

10. If the event was not reported immediately, why not?

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

12. Did employee sign and return claim form (DWC-1)?
☐ Yes (Date:_____) ☐ No

13. Type of medical treatment required:
- ☐ No treatment needed
- ☐ Paramedics or EMT
- ☐ Emergency Room
- ☐ Hospitalized overnight
- ☐ Medical treatment refused
- ☐ First Aid
- ☐ Clinic

14. Medical treatment provider: (name and address of facility)
_____
_____
_____
☐ Check if this is pre-designated provider

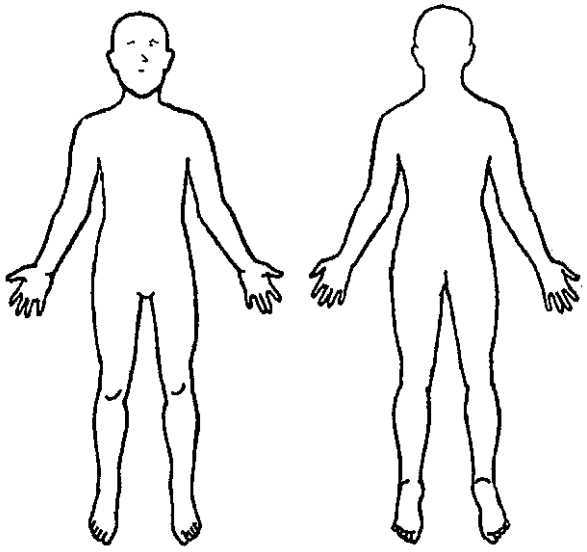
15. What was the employee doing at the time of the event? (attach separate sheet if necessary)
_____
_____
_____

16. Describe how the event occurred: (attach separate sheets if necessary)
_____
_____
_____

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

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

19. Mark affected area(s) on diagram:



20. Did employee lose time from work? ☐ No ☐ Yes – First day of lost time: _____

21. Has employee returned to work? ☐ No ☐ Yes – Date returned: _____
☐ Full duty ☐ Modified duty-Describe:_____

(Rev. 12/2015 mlc)

Supervisor's Report Employee's Name: _____

22. Was the event witnessed? □ No □ Yes – List witnesses (Attach separate sheet if necessary)

Name: _____ Name: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Telephone: _____ Telephone: _____

23. Check all conditions or actions that apply:

EQUIPMENT
- □ Defective machine
- □ Machine guards not in place
- □ Machine guards missing – need to be installed
- □ Improper tools
- □ Defective tools
- □ Improper protective equipment
- □ Defective protective equipment
- □ Inadequate protective equipment
- □ Other: _____

ENVIRONMENT
- □ Arrangement of equipment, work flow, tools
- □ Poor housekeeping – cleanliness and organization
- □ Inadequate lighting
- □ Inadequate ventilation
- □ Signs – inadequate signs or other forms of warning
- □ Walking surface
- □ Other: _____

PROCEDURE
- □ Unsafe procedures
- □ Procedures missing
- □ Procedures inadequate
- □ Other: _____

TRAINING
- □ Associate(s) lacks training
- □ Associate(s) needs retraining
- □ Other: _____

SUPERVISION
- □ Procedures not enforced
- □ Use of protective equipment not enforced
- □ Use of machine guards not enforced
- □ Other: _____

WORKER
- □ Horseplay, unsafe behavior
- □ Short cuts, carelessness
- □ Distracted, inattentive
- □ Other: _____

24. Describe the steps recommended or taken to prevent a recurrence:

_____
_____
_____

25. List any employer property that was damaged and describe the damage:

_____
_____
_____

26. Was the event caused by, or involve, a third party? □ No □ Yes – complete below.

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

Name and address of third party: _____
Description of involvement: _____

27. Other information:

Photographs taken? □ No □ Yes – by whom: _____
Police or fire called to event? □ No □ Yes – Agency: _____
Cal/OSHA contacted? □ No □ Yes – by whom: _____
Evidence preserved (contact Risk Management for guidance)? □ No □ Yes – by whom: _____

28. Comments: (Attach separate sheet if necessary)

_____

Completed by (print name): _____ Date: _____

Signature: _____ Phone no.: _____

□ Attachments

CONCENTRA INDUSTRIAL CLINIC

15768 ARROW HWY, IRWINDALE, CA 91706

(626) 969-9800 HOURS: 24/7 OPEN 7 DAYS

TREATMENT AUTHORIZATION FORM

Employee is being sent for:

☑ Work-Comp Injury ❑ Pre-Placement ❑ Drug Screen

❑ DMV Exam ❑ TB Testing ❑ Immunization

❑ Annual Employee Exam ❑Other_____

REQUIRED INFORMATION:

Employee and Injury Information

Employee Name_____Birth Date_____

Date of Injury _____Date Last Worked _____SS#_____

Injury Location _____

Occupation _____Date of Hire _____

Employer Information

Employer TEMPLE CITY UNIFIED SCHOOL DISTRICT

Address 9700 LAS TUNAS DRIVE, TEMPLE CITY, CA 91780

Fax # (626) 309-0493 Phone # (626) 548-5119

Authorized by MARIA CABRERA mcabrera@tcusd.net _Title EXECUTIVE ASST., BUSINESS SERVICES

Signature _____Date_____

Comments: _____

_____

_____

Insurance Carrier Information

W/C Insurance Carrier SEDGWICK INSURANCE

Contact Name JOHN ANDERSON Title INDEMNITY EXAMINER

Phone # (951) 231-6834 Fax (866) 548-2637 Email john.anderson@sedgwick.com