Risk Management Handbook

Index

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: District Approved Drivers

FROM: Risk Management

SUBJECT: **AUTO ACCIDENT**

IF YOU HAVE AN ACCIDENT

- STOP IMMEDIATELY and take all necessary precautions to prevent further accidents at the scene.
- SEND FOR HELP. Don't leave the accident scene. Ask a passing motorist or some other person to contact the Police, and seek necessary medical assistance.
- RENDER ALL REASONABLE ASSISTANCE to injured persons. Movement of injured person should not be undertaken if likely to cause further injury.
- GET NAMES OF WITNESSES complete the Accident Report Form.
- EXCHANGE INFORMATION with opposing party.
- REPORT THE ACCIDENT. Fill out the report form and notify your supervisor.
- DO NOT make a statement of any kind to anyone other than your employer, our claims representative and the Police.

IMPORTANT!

IF ANYONE IS INJURED, A POSSIBILITY OF INJURY EXISTS, OR IF THERE APPEARS TO BE PROPERTY DAMAGE-PLEASE CALL RISK MANAGEMENT, AS SOON AS POSSIBLE, AT 909-418-6543.

DISTRICT VEHICLE INFORMATION

DRIVER: _____

LICENSE #:_____

VEHICLE YEAR; MAKE; MODEL: _____

_____

VEHICLE LICENSE #: _____

AREA OF DAMAGE:_____

_____

DESCRIBE HOW ACCIDENT OCCURRED

_____

_____

_____

_____

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_____

_____

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_____

_____

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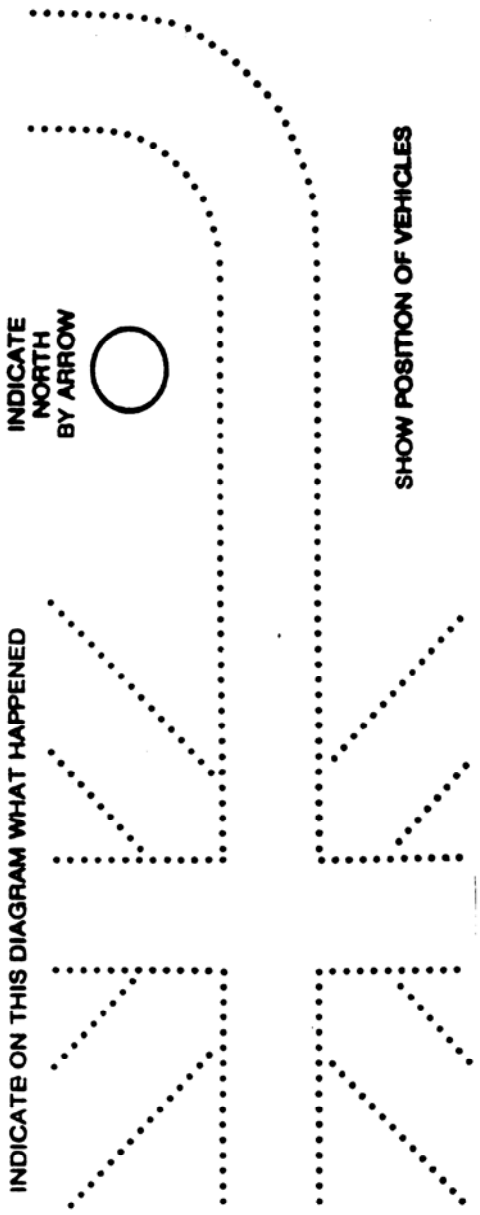
_____

DIAGRAM OR ADDITIONAL NOTES:



ALLIANCE OF SCHOOLS FOR COOPERATIVE INSURANCE PROGRAMS

ASCIP

ACCIDENT REPORT FORM

Submit To:

ASCIP CLAIMS
16550 Bloomfield Avenue
Cerritos, CA 90703
Tel: 562-404-8029
Fax: 562-404-4515

This vehicle is owned/leased by
Ontario-Montclair School District
a public entity, as defined in Section 811.2 of the Government Code and is permissibly self-insured through the Alliance of Schools for Cooperative Insurance Programs (ASCIP, a Joint Powers Authority. Pursuant to Section 16020(b)(2) and (b)(4) of the California Vehicle Code (CVC), evidence of financial responsibility is established through public agency status and qualification as a self-insurer.

SCHOOL DISTRICT _____

ACCIDENT DATE _____ **TIME** _____

LOCATION _____

POLICE AGENCY CALLED_____

TIME NOTIFIED _____

OTHER PARTY

NAME _____

ADDRESS _____

_____

HOME PHONE # _____

WORK PHONE # _____

DRIVER'S LIC.# _____

VEHICLE YR. & MAKE _____

LICENSE NUMBER_____

AREA OF DAMAGE _____

PRIOR DAMAGE _____

OTHER PARTY'S INSURANCE INFORMATION

INSURANCE COMPANY _____

ADDRESS _____

POLICY NUMBER_____

TELEPHONE NUMBER _____

TOTAL # OF INDIVIDUALS INJURED_____

INJURED PARTY #1:

NAME_____ AGE_____

ADDRESS_____

HOME PHONE # _____

WORK PHONE # _____

NATURE OF INJURY _____

WHICH VEHICLE: [ ] DISTRICT [ ] OTHER

INJURED PARTY #2:

NAME_____ AGE_____

ADDRESS_____

HOME PHONE # _____

WORK PHONE # _____

NATURE OF INJURY _____

WHICH VEHICLE: [ ] DISTRICT [ ] OTHER

INJURED PARTY #3:

NAME_____ AGE_____

ADDRESS_____

HOME PHONE # _____

WORK PHONE # _____

NATURE OF INJURY _____

WHICH VEHICLE: [ ] DISTRICT [ ] OTHER

If necessary, list additional injured parties on reverse side or attach additional sheet

WITNESS #1:

NAME _____

ADDRESS _____

_____

HOME PHONE #_____

WORK PHONE # _____

WITNESS #2:

NAME _____

ADDRESS _____

_____

HOME PHONE #_____

WORK PHONE # _____

WITNESS #3:

NAME _____

ADDRESS _____

_____

HOME PHONE #_____

WORK PHONE # _____

ADDITIONAL INFORMATION

OFFICER'S NAME_____

POLICE REPORT # _____

If necessary, list additional witnesses on reverse side or attach additional sheet

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: Principals

FROM: Vanessa Eastland, Chief Financial Officer

SUBJECT: **Automated External Defibrillators (AEDs) - PSRs and Account Strings**

All CERT members are required to be CPR certified. Account strings and PSRs have been created and need to be included on employees' timesheets to account for the additional time for the AED/CPR certification trainings. Please do not charge the additional time related to the trainings to the site budget. Instead, we have created PSR's for each job classification.

A list of names will be submitted to Payroll based on the CERT Rosters. Payroll will cross reference the names on the list to the timesheets that are submitted. Continue to follow the normal timesheet/timecard process. However, please ensure employees specify on their timesheets the extra time is for the AED/CPR training.

Please email Risk Management at Risk.Mgmt@omsd.net for PSR and account strings for time cards.

Thank you,

Vanessa Eastland, CPA
Chief Financial Officer

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: All Employees

FROM: Risk Management

SUBJECT: **AUTOMATED EXTERNAL DEFIBRILLATORS (AED'S) EMPLOYEE NOTIFICATION**

Effective July 1, 2019, Ontario-Montclair School District has installed Automated External Defibrillators (AEDs) in each of the District's schools and administrative facilities. Assembly Bill 2009 requires that if a district or charter school elects to offer any interscholastic athletic programs, the district or charter school shall acquire at least one AED for each school and administrative facility within the school district or the charter school.

The AEDs have been strategically placed at each site and readily accessible to predetermined AED users to maximize rapid use. Each site/department will develop a CERT (cardiac emergency response team) that will be trained and CPR/AED certified. The AED will be available during school hours and after school during on-site school activities.

For additional questions, please contact us:

Brenda Rios – Health Services ext. 10631

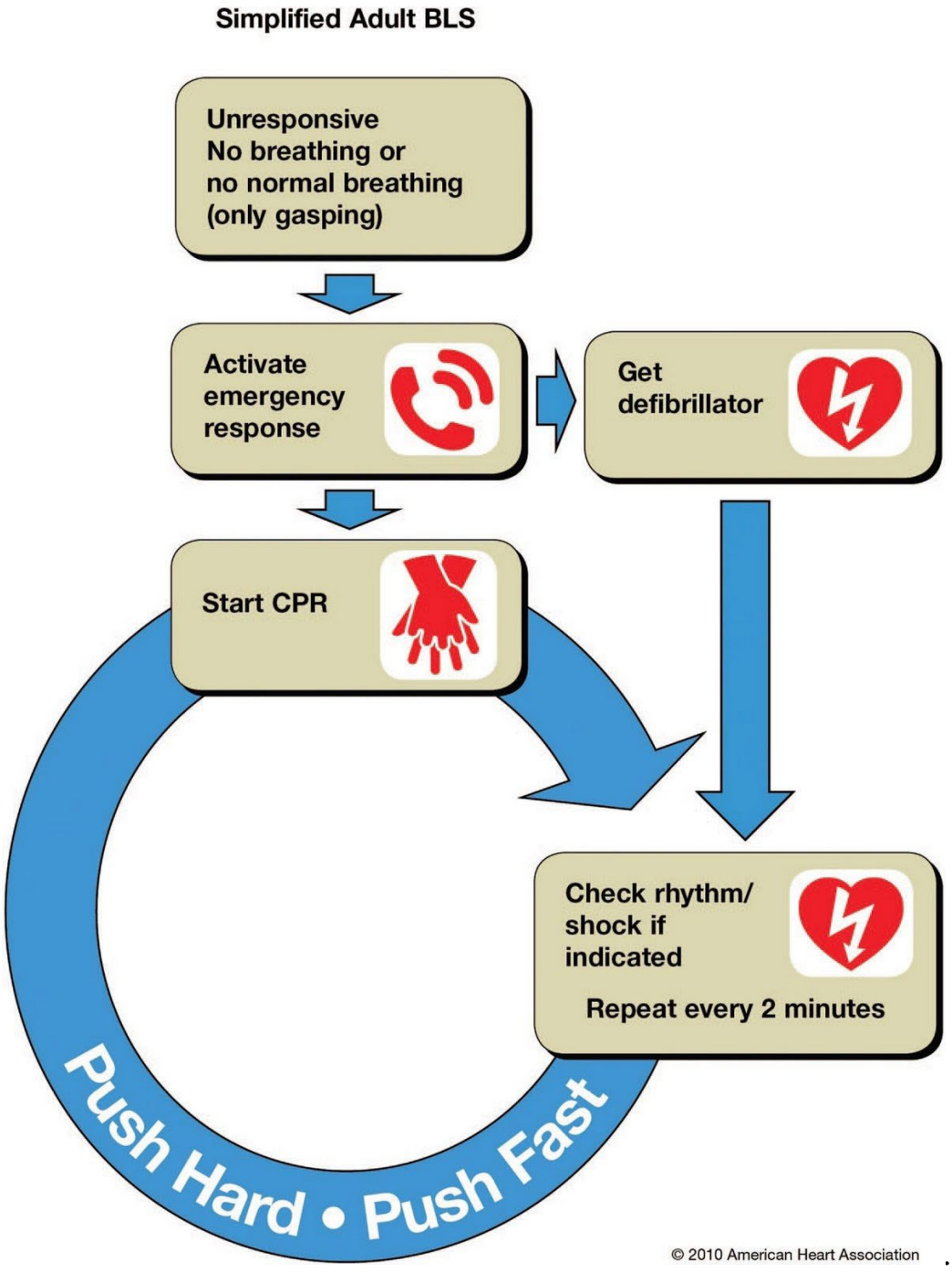
Jessica Flores – Risk Management ext. 10543

Vanessa Eastland – Chief Financial Officer ext. 10446

Phil Hillman – Chief Business Official ext. 10450

Ontario-Montclair School District

CARDIAC EMERGENCY RESPONSE TEAM PROTOCOL



UPDATED 2019-07-02

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: Principals, Assistant Principals, School Administrative Asst., Nurses, Health Asst.

FROM: Risk Management

SUBJECT: **ANNUAL CLASSROOM BACKPACK INSPECTIONS**

Classroom backpacks should be inspected annually prior to the end of each fiscal year and any findings should be reported to Risk Management by submitting the Classroom Backpack Replenishment form by April 15th.

1. Classroom backpacks should not have any tears, holes or missing straps.
2. Please toss any emergency food bars, water pouches, and any medical supplies that have expired.
3. Make sure all items listed on the Classroom Backpack Checklist are found inside the backpack.
4. Submit Classroom Backpack Replenishment form to Risk Management.

Please keep in mind that sites may request replenishment at District expense under the following conditions:

- When the site has depleted supplies due to an actual/precautionary lockdown or evacuation incident, and has documented both the incident and the consumed items.
- When the site has incurred a loss of the supplies due to theft or vandalism (please complete a *LOST, STOLEN OR DAMAGED DISTRICT – OWNED PROPERTY REPORT* form).
- When items become unusable (i.e., product expiration).

Site's budget will cover the expense due to the following conditions:

- Disaster supplies were used in connection with day-to-day operations.
- Disaster supplies are lost, missing, or damaged (e.g., misplaced during teacher relocation or due to unauthorized use).

Please ensure emergency backpacks remain in the assigned classroom, as much as possible, be placed in a consistent location for every classroom, and complete an inventory of items annually. Your assistance with this matter is appreciated. If you have any questions or concerns, please contact Risk Management at (909) 459-2500 ext. 10543.

CLASSROOM BACKPACK REPLENISHMENT FORM

Please submit request to Risk Management via email at Risk.Mgmt@omsd.net. Once the request is received Risk Management & Business Services will review the request. ***The request is subject to a supply audit***.

Department/Site: _____ **Date:** _____

Requested by: _____

Reason for Replenishment: _____ **Other:**_____

Qty.	Items	Price per Unit	Total Price
	Whole backpack (all items below included)	$133.52	
	Heavy duty backpack	$11.50	
	Leather palm gloves	$3.99	
	Non-Latex Gloves	$0.20	
	1 x 1/2" Masking Tape	$0.59	
	Rechargeable Flashlight	$5.95	
	Rope (100")	$17.98	
	Safety Goggles	$2.50	
	Dust Mask	$2.98	
	EMT Scissors 7 1/2"	$3.95	
	4 x 4" Gauze Dressing	$7.88	
	Light Sticks (12 hr.)	$1.25	
	2" Duct Tape	$5.99	
	Adhesive Tape 1/2" x 5 yd.	$0.59	
	Gauze Forceps, Plastic	$2.49	
	Band Aids	$2.99	
	Emergency Blanket (Mylar)	$1.29	
	Triangular Bandages	$0.89	
	Cotton Q-Tip	$1.50	
	Antiseptic Towelettes	$3.99	
	First Aid Guide	$1.95	
	Instant Ice Pack	$0.98	
	CPR Mouth Barrier (Kit)	$4.99	
	Tongue Depressors	$6.50	
	Sanitary Pad	$0.39	
	ABD Pad 5 x 9"	$0.39	
	2-inch Sterile Roller Bandages	$0.79	
	3-inch Sterile Roller Bandages	$0.85	
	Assorted Sizes of Safety Pins	$3.99	
	Antiseptic A&E Cream	$3.98	
	Tweezers	$1.20	
	Whistle	$0.98	
	Safety Vest	$4.95	
	Large Closeable Bags	$2.50	
	Blood Borne Pathogen Cleanup Kit	$6.99	
	Emergency Food Bars	$2.00	
	Emergency Water Pouches	$0.50	
		Total:	$0.00

Office Use: ☐ Approved ☐ Denied: _____

Signature: _____ Date: _____ Revised: 07/2023

Classroom Backpack Checklist

Qty.	Contents	Qty.	Contents	Qty.	Contents
1	Heavy duty backpack	1	Gauze Forceps, Plastic	2	3-inch Sterile Roller Bandages
1 pair	Leather palm gloves	10	Band Aids	1 pk.	Assorted Sizes of Safety Pins
2 pair	Non-Latex Gloves	1	Emergency Blanket (Mylar)	2	Antiseptic A&E Cream
1	1x ½' Masking Tape	2	Triangular Bandages	1	Tweezers
1	Rechargeable Flashlight	5	Cotton Q-Tip	1	Whistle
1	Rope (100')	12	Antiseptic Towelettes	1	Safety Vest
1	Safety Goggles	1	First Aid Guide	2	Large Closeable Bags
1	Dust Mask	1	Instant Ice Pack	1	Blood Borne Pathogen Cleanup Kit
1	EMT Scissors 7 1/2"	1	CPR Mouth Barrier		
2	4"x 4" Gauze Dressings	2	Tongue Depressors		Emergency Food Bars
1	Light Sticks (12 hr.)	2	Sanitary Pads		Emergency Water Pouches
1	2" Duct Tape	2	ABD Pad 5"x 9"		
1	Adhesive Tape ½" x 5 yd.	2	2-inch Sterile Roller Bandages		

Teacher Name: _____ Room#: _____

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: Principals, Assistant Principals, Administrative Assistant

FROM: Risk Management

SUBJECT: **OSHA INSPECTOR GUIDELINES**

IF YOU HAVE AN INSPECTOR ARRIVE AT YOUR SITE:

- Ask the Inspector for clarification about the objective of their visit.
- Verify their identity by requesting identification and a Cal OSHA business card.
- Reach out to the Business Division (see attached contacts in RED).
    - A District representative should arrive as soon as possible, but no later than 1 hour to assist the inspector.
- If a District representative is not available, the site administrator will accompany the inspector to the specific work area in question.
- Please refer to attached Guideline for details of what to expect during the inspection.
- Always notify Risk Management if an inspection is underway.

If you have any questions or concerns, please contact Risk Management at (909) 418-6454.

ACTIONS TO TAKE WHEN Cal/OSHA ARRIVES AT YOUR SITE

INTRODUCTION

- The Occupational Safety and Health Act of 1970 (OSHA) requires covered employers to furnish "a place of employment which is free from recognized hazards that are causing or likely to cause death or serious physical harm". In addition, all Cal/OSHA safety and health standards must be met.
- The law is enforced by both federal and state agencies whose inspectors visit work sites, most often unannounced, to review records concerning employee injury and illness, and to conduct inspections.

WHAT LEADS TO AN OSHA INSPECTION?

- A Cal/OSHA inspection may occur due to employee complaints, workplace fatalities, and sometimes-particular industries are programmed for inspection. In addition, follow-up inspections are often made after initial inspections.

PURPOSE OF THIS GUIDELINE

- It is the guideline of the District that all school sites and District departments shall immediately notify one of the following whenever a Cal/OSHA Compliance Representative is at a District worksite:
  - **Phil Hillman, Chief Business Official, Cell: 909-717-8924**
  - **Brooke Murray, Director, Facilities/Planning/Operations, Cell: 657-203-1784**
  - **Doug Jones, Supervisor of Operations / Regulatory Compliance, Cell: 909-917-5290**
  - **Vanessa Eastland, Chief Financial Officer, Cell: 909-241-6292**
- This document has been established to communicate the School District's guidelines on the procedures to follow whenever the California Division of Occupational Safety and Health (Cal/OSHA) inspections are made on district property. All departments and employees shall comply with the requirements of this guideline.

Who Does it?	What Actions Should Be Taken?
Office Assistant, Administrative Assistant	➢ To initiate a typical inspection, the Cal/OSHA inspector, entering via the main entrance, will provide credentials and ask to meet the management representative. Verify the Cal/OSHA inspector's identity by requesting identification, a Cal/OSHA business card and the nature of the visit. Note: If an inspection is being conducted because of an imminent hazard, the Inspector, after identifying themselves, will ask to be taken to the imminent hazard immediately to remove any employees from exposure to the imminent hazard. ➢ Contact the **Site Administrator.** ➢ Contact the District Office Representatives listed above (in Red) until you reach someone other than voice mail.
Department Director, Site Administrator	➢ Meet with the Cal/OSHA inspector to discuss the nature of the visit. Do not refuse entry or ask the inspector to come back at a more convenient time. Doing so could result in Cal/OSHA obtaining a court ordered inspection warrant, which may expose the District to a more exhaustive inspection. ➢ If necessary, Site Administrators or Department Directors will inform the Cal/OSHA inspector that per District guidelines, you have been directed to wait for the designated District representative before proceeding with an opening conference and inspection. The Cal/OSHA inspector may allow up to one hour before proceeding with the inspection. If the designated District representative is not available, the Site Administrator or Department Director will accompany the Cal/OSHA inspector throughout the inspection. ➢ In the absence of the District Office Representative Management Level or his designee, you will serve as the District's Representative at the site representative during the inspection and must also accompany the Cal/OSHA inspector throughout the inspection.

Department Director, Site Administrator, or District Office Representative	**Opening Conference:** ➢ Once you determine the reason for the inspection, try and limit the extent of the inspection to that reason. ➢ Remain courteous and answer questions truthfully but do not offer information beyond what they are asking for or speculate when responding to questions. ➢ Avoid making any statements that the Cal/OSHA inspector could construe as an admission of violating any laws or regulations. If the inspection is related to an accident and the District's internal accident investigation is not yet completed, do not speculate as to the cause of the accident or how it could have been prevented. All information expressed should be accurate and factual. Never relay information that is hearsay. ➢ Provide only requested documents rather than giving free access to document storage.
Department Director, Site Administrator, or District Office Representative	**Site Inspection:** ➢ If the Cal/OSHA inspector requests an inspection of a work area, choose a path to the inspection area carefully. Avoid any areas that are under construction or where Maintenance & Operations may be working. ➢ If possible, do what you can to immediately correct any hazards that are found during the inspection. ➢ Take notes during the opening conference and take the same pictures during the inspection that the Cal/OSHA inspector took. ➢ If environmental monitoring or sampling was taken, ask what was sampled and what sampling method was used. What were the results, if any, of any direct reading devices?
Department Director, Site Administrator, or District Office Representative	**At the Closing Conference:** ➢ Take notes of alleged violations of standards that the Cal/OSHA inspector discusses with you and any requirements for abatement. Without admitting a violation, estimate the time, if possible, for any corrective action to be taken. ➢ Attempt to clarify whether or not a citation(s) will be issued or if a follow-up inspection will be conducted. ➢ Provide the Cal/OSHA inspector with your telephone number, the correct name of your site or department and the mailing address for future correspondence. Request that copies of all future correspondence also be sent to the District Office (Attention: Risk Management) at 950 West D Street, Ontario, CA. ➢ Upon completion of the inspection and closing conference, prepare a report of the inspection incorporating any notes and/or photographs taken and statements made by you and/or the Cal/OSHA inspector. Provide copies for the District office file.

WHAT TO EXPECT ON A Cal/OSHA INSPECTION

- A Cal/OSHA Compliance Representative hereinafter referred to as "Inspector" is directed to follow these procedures when conducting an inspection at a worksite:

❖ INITIAL CONTACT

The Inspector must:

- Present their State of California photo identification card and Division of Occupational Safety and Health business card to the initial contact person at the worksite.
- Request permission to conduct an inspection from a management-level representative of the employer.

❖ OPENING CONFERENCE

During the opening conference with an employer representative (i.e., a management-level representative at the worksite), the Inspector will:

- Explain the reason for and scope of the inspection. (If the Inspector is responding to a Complaint Inspection, they are not allowed to provide the employer with a copy of the complaint, the identity of the complainant(s) or any of the specific complaint items.
- Ask to review the Employer's occupational safety and health records (i.e., inspections, training records, the written Injury and Illness Prevention Program, but not the OSHA 300 Log, and, if applicable, any permits and registrations.

❖ **WALKAROUND INSPECTION**

The Inspector will conduct an inspection for the purpose of determining whether or not the workplace complies with California Code of Regulations, Title 8. The Inspector will ask for an Employee Representative to accompany them during the walk around inspection. During the inspection:

- Employees may be interviewed.
- Photographs may be taken.
- Testing and environmental samples may be taken. Note: If the Inspector concludes that an imminent hazard condition or practice exists at the workplace, an Order Prohibiting Use (yellow tag) can be issued which prohibits employee use of the area, machine or equipment that presents the hazard. Only the Inspector can remove the yellow tag when the hazardous condition is corrected.

❖ **CLOSING CONFERENCE**

At the conclusion of the inspection, the Inspector will discuss:

- Any alleged violations observed and any requirements for abatement.
- Possibility of a follow-up inspection.
- Employer's right to appeal any and all citations.
- Abatement period for any citations.
- Right to request an informal conference with the Cal/OSHA District Manager.
- Employer's responsibility to post citations.

Cal/OSHA INSPECTION CRITERIA AND PRIORITIES

❖ **INSPECTION CRITERIA**

Cal/OSHA inspections are based on one or more of the following criteria:

- Accident. An inspection resulting from a report of a fatality, catastrophe, or serious injury or illness.
- Complaint (Formal). An inspection of a valid complaint filed by an employee, Employee Representative, or Employer of an Employee.
    - Imminent danger. Immediate inspection.
    - Government agency.
    - Media report.
    - Follow-up. An inspection conducted to determine whether the employer has abated violations previously cited on an inspection.

❖ **INSPECTION PRIORITIES**

Cal/OSHA inspections may be conducted based on the following priorities:

- Imminent danger.
- A fatality or serious accident
- Employee complaints.
- Programmed high-hazard inspection.
- Follow-up inspection.

Cal/OSHA Compliance Personnel are not permitted to give an employer advance notice that an inspection is to be conducted, except by specific permission of the Cal/OSHA Chief or authorized representative (CCR, Title 8, and Section 331).

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: Principals, Assistant Principals, School Administrative Assistants

FROM: Risk Management

SUBJECT**:** **CONFIDENTIAL SCHOOL INCIDENT REPORT**

- Submit the Confidential School Incident Report via FAX (909) 459-2565 or by email to: Risk.Mgmt@OMSD.net within 24 hrs. of incident.
- Form must be thoroughly filled with as much information as possible. Risk Management will send back any forms to the school site if there are any questions or missing information.
- Ensure witness statements are provided, if applicable.
- *This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not district employees.*
- If a parent is requesting a copy of the Confidential School Incident Report, please complete the second page of this document called "Ontario-Montclair School District School Incident Report". Please send this page to Risk Management for review. Once it has been approved you may provide that page to the parent. Please send Risk Management a copy of the signed document given to parent via fax or email.

If you have any questions or concerns, please contact Risk Management at (909) 418-6543

Confidential School Incident Report

Ontario-Montclair School District

950 West D Street • Ontario, CA 91762

CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE
This report is to be completed by district employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not district employees and/or their legal representatives.
IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY.

DATE OF REPORT	NOTE: The district employee either witnessing the incident or supervising at the time should complete and submit this form within 24 hours. This is an interactive form.

NAME OF SCHOOL DISTRICT/ COLLEGE DISTRICT		NAME OF SITE	
ADDRESS OF SITE (NUMBER, STREET, CITY, STATE AND ZIP CODE)			
NAME OF INJURED PERSON (LAST, FIRST, M.I.)	AGE	GRADE	TELEPHONE NUMBER OF INJURED PERSON
IS INJURED PERSON A MINOR ☐ NO ☐ YES	NAME OF PARENT OR LEGAL GUARDIAN		
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)			
WHERE DID INCIDENT OCCUR (ON/OFF SITE, WHERE SPECIFICALLY)	DATE OF INCIDENT (MONTH/DAY/YEAR)	TIME ☐ A.M. ☐ P.M.	
DESCRIBE HOW INCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)			

FULL NAME OF PERSON IN CHARGE AT TIME OF INCIDENT	TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)	WAS HE/SHE PRESENT AT THE TIME? ☐ NO ☐ YES	INJURED VIOLATED SCHOOL RULE? ☐ NO ☐ YES
NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NUMBER	TITLE

APPARENT NATURE OF INJURY (PLEASE CHECK)			INJURED PART OF BODY (PLEASE CHECK)			
☐ Abrasion	☐ Fracture	☐ Strain/Sprain	☐ Head	☐ Finger	☐ Arm	☐ Abdomen
☐ Contusion	☐ Cut	☐ Dislocation	☐ Neck	☐ Eye	☐ Leg	☐ Hand
☐ Internal	☐ Concussion		☐ Back	☐ Chest	☐ Face	☐ Foot
☐ Other			☐ Other			

FIRST AID PROCEDURES USED	NAME OF PERSON WHO ADMINISTERED FIRST AID

DISPOSITION OF INJURED AFTER INCIDENT ☐ Home ☐ Doctor ☐ Hospital ☐ Classroom	WHO WAS NOTIFIED	RELATIONSHIP TO INJURED	FORM GIVEN?*** ☐ YES ☐ NO

IF INJURED PUPIL LEFT SITE TO WHOM RELEASED	NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL/ DISTRICT
IS STUDENT INCIDENT BENEFITS AVAILABLE? ☐ NO ☐ YES	NAME OF COMPANY
REMARKS	

For your protection, California law requires the following to appear on this form. "It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance; (b) prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding 3 years or by fine not exceeding $1,000 or by both."

NAME OF PERSON COMPLETING REPORT	TITLE	TELEPHONE
ADDRESS OF PERSON (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)		
SIGNATURE OF PERSON APPROVING REPORT	DATE SIGNED	PERSON WAS AN EYE WITNESS

RESET FORM

SUBMIT FORM TO RISK MANAGEMENT:
EMAIL: *Risk.Mgmt@omsd.net or*
FAX: (909) 459-2565

EMAIL FORM

Please distribute the School Incident Report (second page) only if the parent is looking for information regarding the student injury.

Revised:
04/2020

Ontario-Montclair School District
School Incident Report

Your student was injured during school. If you have any additional questions feel free to call the school's office.

NAME OF SCHOOL DISTRICT/ COLLEGE DISTRICT	NAME OF SITE

NAME OF INJURED PERSON (LAST, FIRST, MI.)	DATE OF INCIDENT (MONTH/DAY/YEAR)

DESCRIBE HOW INCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)

APPARENT NATURE OF INJURY (PLEASE CHECK)			INJURED PART OF BODY (PLEASE CHECK)			
☐ Abrasion	☐ Fracture	☐ Strain/Sprain	☐ Head	☐ Finger	☐ Arm	☐ Abdomen
☐ Contusion	☐ Cut	☐ Dislocation	☐ Neck	☐ Eye	☐ Leg	☐ Hand
☐ Internal	☐ Concussion		☐ Back	☐ Chest	☐ Face	☐ Foot
☐ Other			☐ Other			

FIRST AID PROCEDURES USED

NAME OF PARENT OR LEGAL GUARDIAN	SIGNATURE OF PARENT OR LEGAL GUARDIAN	DATE

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: Principals, Asst. Principals, School Administrative Assistants

FROM: Risk Management

SUBJECT: **INSTRUCTIONS FOR FILING A LOST, STOLEN OR DAMAGED DISTRICT OWNED PROPERTY REPORT**

- Notify All losses to Risk Management right away regardless of the cost to repair or replace.
- In the event of theft or property damage resulting from forced entry and/or burglary, the appropriate law enforcement agency needs to be notified and documented.
- Complete the Lost, Stolen or Damaged District Owned Property Report and submit to Risk Management, this should include inventory of all damages.
- Proceed with replacements/repairs once approval is received from Risk Management.

For Lost/Stolen Property:

- Complete the Lost, Stolen or Damaged District Owned Property Report and submit Police Report#.
- School site/Department will complete a requisition for the replacement item and submit a copy of the requisition and new purchase order.
- In Financial 2000, under ***Description***, type in "*replacement of missing, stolen or damaged item & date of occurrence"* when completing the requisition.
- If item is $300 or less, the item should be replaced by the school site/department's budget. If the item is over $300, the item should be replaced by Risk Management minus $300 of total balance.
- Once Risk Management receives the Lost, Stolen or Damaged District Owned Property Report along with police report, Risk Management will provide approval and account line to use for replacement of items.
- A copy of the requisition and purchase order must be submitted to Risk Management.

For Damaged Property:

- Complete the Lost, Stolen or Damaged District Owned Property Report and submit Police Report#.
- Take pictures of property loss from different angles.
- Obtain estimates for repairs.
- *Please note that no repairs should be started or completed until a purchase order is generated and approval to proceed is given.*
- Once Risk Management receives the Lost, Stolen, or Damaged District Owned Property Report, Police Report, and copy of estimate, Risk Management will provide approval and account line to use for replacement of items.
- The school site/department site will be responsible for creating the requisition.
- In Financial 2000, under ***Description***, type in "*replacement of missing, stolen or damaged item & date of occurrence"* when completing the requisition.
- A copy of the requisition and purchase order must be submitted to Risk Management.

ONTARIO-MONTCLAIR SCHOOL DISTRICT

Lost, Stolen or Damaged District Owned Property Report

Site: _____ Building/Rm#: _____ Loss Discovered by: _____

Date of Loss: _____ Date Reported: _____ If not Reported to Police, Reason: _____

Date Reported to Police: _____ Police Department: _____

Responding Officer's Name: _____ Badge# _____ Report# _____

School Site/Department Site Budget Line: _____

EQUIPMENT (if leased, insert asterisk after description and enter name of lessor in remarks)

Item Description (make/model#) (use separate sheet of paper if more than five)	**Asset Inventory** (Tag#)	**Mfg. Serial#**	**Value ($)**	**Status***

* **STATUS CODE: D= Damaged, S=Stolen, L=Lost, V=Vandalism**

Steps taken to recover/remarks:

BUILDING OR PROPERTY DAMAGE/LOSS (Please submit photos of damages along with this form)

Describe type of entry (forced, key, etc.):

Cause of Damage or Loss (Fire, Wind, Vandalism, Rain, Theft, Etc.):

Full Description of Damage or Loss:

Signature of Site Administrator _____ **Date:** _____

Risk Management Signature _____ **Date:** _____

Claim#_____

ORIGINAL to Risk Management, **COPY** for Site Administrator/Supervisor

Updated: 08/2021

ONTARIO-MONTCLAIR SCHOOL DISTRICT

RISK MANAGEMENT

TO: All Employees

FROM: Risk Management

SUBJECT: **PROCEDURE FOR REPORTING EMPLOYEE WORK RELATED INJURIES**

Company Nurse Injury Hotline: 1-866-955-2649

- When an injury or incident occurs you MUST INFORM YOUR SUPERVISOR AND CALL Company Nurse.
- You DO NOT need to seek medical attention if you feel you don't need to, but you must call Company Nurse to report the injury or incident.
- Company Nurse is called, by the employee, for work-related injuries only. They use a triage process that will guide the employee to the correct level of care for treatment based on the information that is obtained from the phone call. Company Nurse will refer the employee to a clinic if treatment is necessary.
- Company Nurse will then notify Risk Management and the claim adjuster that an injury or incident has occurred.
- When seeking medical attention, the employee and the school site/department, are required to complete the *Injury/Illness Exposure Report, Workers' Compensation Claim Form (DWC-1), Acknowledgment of MedEx Advantage MPN and Supervisor Report.*
- It is not necessary for the employee to fill out the workers' compensation packet if the employee is not seeking medical attention. However, on the day of the incident the employee will need to complete the *Injury/Illness Exposure Report* and submit a copy to the Supervisor. The Supervisor must complete the Supervisor *Report* and submit a copy to Risk Management.
- Once the forms are completed and signed, email a copy of the forms to Risk.Mgmt@omsd.net or fax a copy to (909) 459-2565 within 24 hours of the injury-taking place. Originals are sent to Risk Management via District Mail.
- After the reporting process has been completed, Risk Management's normal procedures will continue by assisting any employees who receive an off work order or modified duty as ordered by their treating physician for the injury.

If you have any questions or concerns please contact Risk Management at ext. 10454 or 10593.

IN CASE OF WORKPLACE INJURY
En caso de un accidente laboral

COMPANY NURSE™ Powered by Lintelio

Available 24/7/365

Phone (Teléfono)

1-(866) 955-2649

Digital, powered by Lintelio
(Digital, implementado por Lintelio)

Employer Name (Nombre De la Compañia)

Ontario-Montclair School District

Search Code (Código De Búsqueda)

ONMSD

1

Injured worker notifies supervisor.
El trabajador herido notifica a su supervisor.

2

Supervisor/Injured worker:

• Calls above number OR
• Scans above code with a smartphone to get to Lintelio app and follows the prompts.

Supervisor / trabajador herido:

• Llama a el número en la parte de arriba O
• Escanea el código de arriba con un teléfono para acceder a la app de Lintelio y sigue las indicaciones.

3

Company Nurse gathers information and helps injured worker access appropriate care. Injured worker notifies Supervisor of the outcome of the call.
Company Nurse obtiene la información y ayuda al trabajador herido a obtener el tratamiento médico adecuado. El trabajador lesionado le notifica a su supervisor el resultado de la llamada.

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.

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.

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

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

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

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

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

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

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

10. Name of employer. *Nombre del empleador.* **Ontario Montclair School District**
11. Address. *Dirección.* **950 West "D" Street, Ontario, CA 91762**
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.* _____
Athens Administrators, PO Box 696, Concord, CA 94522
16. Insurance Policy Number. *El número de la póliza de Seguro.* **Self-Insured**
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

ONTARIO-MONTCLAIR SCHOOL DISTRICT
INJURY/ILLNESS/EXPOSURE REPORT

THIS FORM MUST BE COMPLETELY FILLED OUT AND TURNED IN OR FAXED/EMAIL TO THE RISK MANAGEMENT OFFICE WITHIN 24 HOURS OF KNOWLEDGE OF INCIDENT.

FAX NUMBER: (909) 459-2565 EMAIL: RISK.MGMT@OMSD.NET

FOR EMPLOYEE'S/VOLUNTEER'S USE

1. Check One: ☐ Employee (Job Title) _____ Or ☐ Volunteer
2. Print Your Name: _____ Site/Dept.: _____
3. Home Address: _____
   Street City Zip
4. Home Phone: _____ 5. Date of Birth: ___ / ___ / ___ 6. SSN: _____
7. Date and Time of Injury/Illness/Exposure: Date ___ / ___ / ___ Time _____ /
   (Circle one)
8. State Specific Part(s) of Your Body Injured/Affected: _____
9. Describe exactly what happened, where & how the incident occurred: _____

   _____

   _____
10. Will you receive medical attention? Yes ☐ No ☐
11. If "Yes," state name, address, and phone number of medical facility to be visited:

    _____
12. Will you leave work? Yes ☐ No ☐ If "Yes," Date ___ / ___ / ___ Time __ /
    (circle one)
13. Names of Witnesses; If none enter N/A: _____
14. Signature: _____ Date: _____ / _____ / _____

FOR SITE/DEPT. ADMINISTRATOR'S USE ONLY

1. Was individual given a Worker's Compensation Claim Form (DWC-1 Form)? ☐ Yes. Date ___ ☐ No
   If "No", Why Not? _____
2. Did a safety violation occur? Check one: ☐ Yes ☐ No If "YES", Explain what will be done to prevent similar injuries/exposures? _____

   _____
3. Site/Dept. Administrator's Signature: _____ Date: _____ / _____ / _____

FOR RISK MANAGEMENT DEPT'S USE ONLY

1. If Employee, Date of Hire: _____ Hours Worked/Week: _____ Monthly Salary: _____
2. Reviewed by: _____ Date: _____

RECEIPT OF WORKERS COMPENSATION INFORMATION

I ACKNOWLEDGE THAT I HAVE RECEIVED THE FOLLOWING DOCUMENTS THAT CONTAIN IMPORTANT INFORMATION REGARDING MY WORKERS' COMPENSATION RELATED INJURY:

☐ **MedEx Advantage MPN - Informational Pamphlet**

☐ **Workers' Compensation Claim Form (DWC-1)**

Employee Name:
Signature:
Employer:
Date:
Email:

If you have any questions, please contact Risk Management at (909) 418-6593.

Supervisor's Report of Injury or Illness

1. Name of employer:	2. Name of supervisor:	3. Department:
4. Employee's name:	5. Job title or position:	
6. Date and time of event:	7. Location or address where event occurred:	7a. On employer property? □ Yes □ No
8. Date of knowledge of the event:	9. Name and title of person to whom the event 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 the 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: (include name and address of facility)

□ Check if this is a 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)

_____

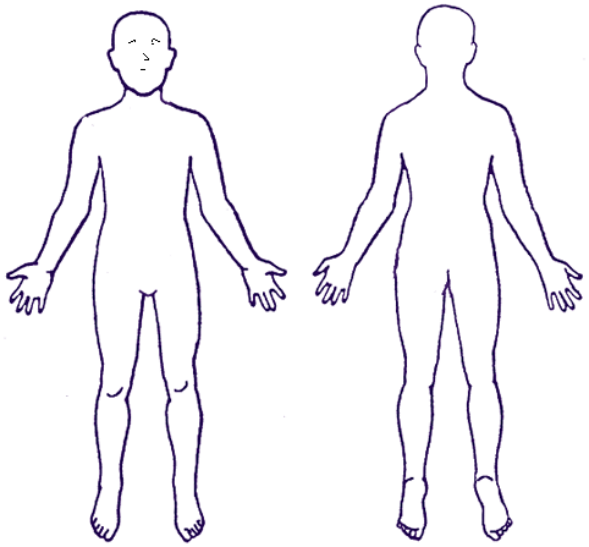
_____

_____

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: _____

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

ONTARIO-MONTCLAIR SCHOOL DISTRICT

Workplace Injury Reporting Procedures Flowchart

IS THIS MATTER AN EMERGENCY?

NO

Contact **Company Nurse** by calling (866) 955-2649 (Search Code: ONMSD)

YES

Call 911 and Notify Risk Management at (909) 418-6593 to determine if OSHA notification is required.

Subsequently, treatment procedure for follow-up care should be followed.

IS TREATMENT REQUIRED?

YES

If the employee has a **pre-designated personal physician**, initial treatment and follow up will occur with said personal physician. MUST have a pre-designation form on file with Risk Management.

If the employee does **NOT have a pre-designated personal physician**, Company Nurse will refer employee to one of our treating clinics.

NO

If the employee is only reporting a workplace incident and does **not** want to seek medical care or if Company Nurse indicates self-care, complete the following forms and submit to Risk Management:

- EMPLOYEE INJURY/ILLNESS/EXPOSURE REPORT
- SUPERVISOR'S REPORT
- RECEIPT OF WORKERS' COMPENSATION ACKNOWLEDGMENT FORM

If employee receives treatment, please provide the following forms to the employee:

- DWC-1 WORKER COMPENSATION CLAIM FORM
- MEDICAL PROVIDER NETWORK INFORMATION – MedEx Advantage MPN (Available in both English and Spanish)
- EMPLOYEE INJURY/ILLNESS/EXPOSURE REPORT
- SUPERVISOR'S REPORT
- RECEIPT OF WORKERS' COMPENSATION ACKNOWLEDGMENT FORM
- MITCHELL FIRST FILL PROGRAM FLYER (provided by Risk Management, if needed)

Send to Risk Management Office within 24 hrs. of reporting injury.

No further action required.

ADDITIONAL INFORMATION

Doctor's Notes and Follow Up

- Upon employees' return to work, send doctor's note to the Risk Management Office. If employee has no work restrictions, please verify with the Risk Management Office by calling (909) 418-6593.
- If an employee **does** have work restrictions, the supervisor is to consult with the Risk Management Office to discuss the employees' return to work and may require an interactive accommodation meeting.
- **NOTE:** It is the employee's responsibility to promptly report his/her work status to their supervisor and/or Risk Management.

Updated: 01/2024