



## Imperial Valley Regional Occupational Program Worker's Compensation Coverage Policy and Procedures

**CALL THE IVROP PERSONNEL DEPARTMENT AT (760) 482-2614 OR  
(760) 482-2611 AS SOON AS THE INJURY OCCURS**

The following forms are necessary to report a work injury:

All forms are available on the IVROP website: [www.ivrop.org](http://www.ivrop.org)

- Employee / participant **must** have authorization from the Personnel Department to seek treatment. Once authorization is given employee / participant must go to one of the facilities listed on form [SISC Medical Provider List](#) and take form [Employee's Ability to Return to Work](#) to treatment facility. The Employee's Ability to Return to Work form must be hand delivered to Personnel after visit with Physician by the injured individual.
- Employee / participant must complete in detail and sign [Worker's Compensation Claim Form\(DWC 1\)](#) this form must be signed by employee / participant and faxed to Personnel at 482-2750 or reported via telephone at 482-2614 or at 482-2611, within 24 hours of injury.
- Supervisor / instructor must complete form [SISC I Employer's Report of Occupational Injury of Illness \(Form 5020\)](#) this form must be completed and also given to Personnel within 24 hours of injury. Please provide as much detail as possible as for the injury occurred or what contributed to the injury (i.e. equipment, safety hazards).
- Supervisor / instructor must complete and sign form [SISC I: Supervisor's Report of Accident](#) this form must be completed, signed and given to Personnel within 24 hours of injury. Please provide as much detail as possible as how the injury occurred and what contributed to the injury (i.e. equipment, safety hazards).

**Original forms must be completed and delivered to the IVROP – Personnel Department with 24 hours of injury.** There is a risk that employee / participant will not be covered by worker's compensation and IVROP will be penalized if forms are not submitted and injury is not reported on time.

Feel free to call the Personnel Department if you have any questions.

Self-Insured Program Of Imperial County  
Medical Provider List  
Self-Insured Schools of California (SISC-I)

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Employee Name: \_\_\_\_\_  
School District: **Imperial Valley Regional Occupational Program**  
Date of Injury: \_\_\_\_\_  
Type of Injury: \_\_\_\_\_  
Supervisor Signature: \_\_\_\_\_

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In the event of an industrial injury, you must seek immediate medical attention at one of the following facilities:

Thomas C. Bruff  
1850 W. Main Street, Suite E  
El Centro, CA 92243  
(760) 370-0020  
(760) 370-0220 Fax

Occupational Health Center  
George Fareed, M.D.  
Lorenzo Muñoz, M.D.  
751 W. Legion Rd., Suite 103  
Brawley, CA 9227  
(760) 351-8696  
1463 S. 4<sup>th</sup> Street, Suite B  
El Centro, CA 92243  
(760) 337-1616

Southwestern Occupational Health  
Services  
Lorenzo H. Suarez, M.D.  
183 S. 5<sup>th</sup> Street  
Brawley, CA 92227  
(760) 344-8100

Industrial Medical & Family Care  
Perry Beal, M.D.  
1441 State Street, Suite B  
El Centro, CA 92243  
(760) 337-1771

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Serious/Life threatening medical emergencies only at one of the following facilities:

El Centro Regional Medical Center  
1415 Ross Ave.  
El Centro, CA 92243  
(760) 339-7100

Pioneer Memorial Hospital  
Occupational Medicine  
207 West Legion Road  
Brawley, CA 92227  
(760) 351-4402

**TO ALL EMPLOYEES:**

If you are injured on the job and do not have a pre-designated physician on file, the following SISC I Medical Provider Network (MPN) medical facilities are authorized to provide treatment to you. You are required to use these providers for work-related injuries or illness.

You have the right to be treated by a MPN physician of your choice after the first visit. You can get a list of MPN providers by calling the MPN contact at (877) 222-4946 or by going to our website at [www.cfmncnet.org/sisc](http://www.cfmncnet.org/sisc).

**IMPERIAL COUNTY**

**PRIMARY OCCUPATIONAL TREATMENT PROVIDER  
(IMMEDIATE MEDICAL ATTENTION)**

Imperial Valley Occupational Medicine  
Thomas C. Bruff, M.D.  
1850 W. Main St., Suite E  
El Centro, CA 92243  
(760) 370-0020

Industrial Medical & Family Care  
Frederick Arbenz, M.D.  
1441 W. State Street, Suite B  
El Centro, CA 92243  
(760) 337-1771

529 E Street  
Brawley, CA 92227  
(760) 344-9000

Occupational Health Center,  
Pioneers Memorial Hospital  
George Fareed, M.D.  
Lorenzo Munoz, M.D.  
751 W. Legion Road, Suite 103  
Brawley, CA 92227  
(760) 351-8696

Southwestern Occupational Health Svcs.  
Lorenzo H. Suarez, M.D.  
183 S. 5<sup>th</sup> Street  
Brawley, CA 92227  
(760) 344-8100

1463 South 4<sup>th</sup> Street, Suite B  
El Centro, CA 92243  
(760) 337-1616

Due to rural areas, the following non-contracted MPN Provider is authorized to provide treatment based on geographical location:

Pinnacle Health Care  
4343 East 31<sup>st</sup> Place  
Yuma, AZ 85365  
(928) 341-4544

**SERIOUS/LIFE THREATENING MEDICAL EMERGENCIES ONLY**

El Centro Regional Medical Center  
1415 Ross Avenue  
El Centro, CA 92243  
(760) 339-7100

Pioneers Memorial Hospital-  
Occupational Medicine  
207 West Legion Road  
Brawley, CA 92227  
(760) 351-4400

**For an emergency or urgent care situation, call 911, or go directly to the nearest emergency room.**

**Effective: 10-01-2007**

**Revised: 04-20-2011**

**SISC I WORKER'S COMPENSATION  
MEDICAL PROVIDER NETWORK  
EMPLOYEE HANDBOOK ACKNOWLEDGMENT**

I have received the following:

1. Medical Provider Network (MPN) Employee Handbook
2. Predesignation of Personal Physician (DWC Form 9783) (New Employees Only)

\_\_\_\_\_  
Employee Name (Please Print)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School District

If you have any questions regarding any of these documents or are in need of additional information, please call the Human Resources Department

RETURN FORM TO HUMAN RESOURCES. RETAIN THE DOCUMENTS LISTED ABOVE FOR YOUR RECORDS
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## Supervisor's Report of Work Related Injury and Illness

### General Information:

Name of injured employee:		Today's date:	
Date of incident/injury:	Date reported:	Time of incident/injury:	
School Site/Department:			
Location of injury/incident:			
Employee #	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:	
Home address:	Phone number where employee can be reached:		
	Job title:		
	Occupation at time of incident:		
	Months/years in occupation:		
	Pre-placement medical evaluation? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
<u>Phase of employee's workday at time of injury or incident</u>			
Break <input type="checkbox"/> Entering or Leaving Facility <input type="checkbox"/> Meal <input type="checkbox"/> Performing Work <input type="checkbox"/> Other _____			
<u>Severity of injury/illness/incident</u>			
Report Only – no treatment <input type="checkbox"/> Physician Treatment <input type="checkbox"/> Light Duty-Temporary Assignment <input type="checkbox"/>			
Lost Workdays-Days Away from Work <input type="checkbox"/> Damage to Equipment, Facility, Etc. over \$500 <input type="checkbox"/>			
Other _____			
<u>Other workers involved or witness to incident (attach eye-witness statements):</u>			

### Injury Information (check all that applies):

<b>Accident Type: (what caused physical harm or discomfort)</b>	<input type="checkbox"/> Contact with	<input type="checkbox"/> Caught on	<input type="checkbox"/> Struck by
	<input type="radio"/> Electricity	<input type="checkbox"/> Cumulative	<input type="checkbox"/> Student caused
	<input type="radio"/> Heat	<input type="checkbox"/> Exposure	<input type="checkbox"/> Over exertion (strain)
	<input type="radio"/> Chemicals	<input type="checkbox"/> Fall from height	<input type="checkbox"/> Other _____
	<input type="radio"/> Cold	<input type="checkbox"/> Slip/Trip/Fall	
	<input type="checkbox"/> Caught between	<input type="checkbox"/> Stress	
	<input type="checkbox"/> Caught in	<input type="checkbox"/> Struck against	
<b>Nature of Injury:</b>	<input type="checkbox"/> Amputation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Puncture
	<input type="checkbox"/> Bruise or contusion	<input type="checkbox"/> Human bite	<input type="checkbox"/> Repeated trauma
	<input type="checkbox"/> Burn	<input type="checkbox"/> Illness	<input type="checkbox"/> Scratch
	<input type="checkbox"/> Cut or laceration	<input type="checkbox"/> Insect bite	<input type="checkbox"/> Strain or sprain
	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Multiple injuries	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Foreign particle in eye		
<b>Part of Body Affected:</b>	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Eyes: R____ L____	<input type="checkbox"/> Knee: R____ L____
	<input type="checkbox"/> Arms: R____ L____	<input type="checkbox"/> Face	<input type="checkbox"/> Legs: R____ L____
	<input type="checkbox"/> Ankle: R____ L____	<input type="checkbox"/> Feet: R____ L____	<input type="checkbox"/> Shoulder: R____ L____
	<input type="checkbox"/> Back	<input type="checkbox"/> Finger: R____ L____	<input type="checkbox"/> Wrist: R____ L____
	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand: R____ L____	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Elbow: R____ L____	<input type="checkbox"/> Head	

*Description of how incident/injury occurred: What happened (if digital pictures are taken list picture reference numbers)?*

(Attach additional pages as necessary.)

## Supervisor's Report of Work Related Injury and Illness

### Contributing Factors

<b>Workplace conditions that may have contributed to the accident</b>	<input type="checkbox"/> Defective tools or equipment <input type="checkbox"/> Excessive noise <input type="checkbox"/> Failure to warn or secure <input type="checkbox"/> Inadequate guard or protection <input type="checkbox"/> Inadequate lighting	<input type="checkbox"/> Indoor air quality <input type="checkbox"/> Substandard housekeeping <input type="checkbox"/> Trip hazard <input type="checkbox"/> Vapor/Fume exposure <input type="checkbox"/> Other _____
<b>Unsafe work practices that contributed to the accident</b>	<input type="checkbox"/> Failure to use personal-protective equip. <input type="checkbox"/> Horseplay <input type="checkbox"/> Improper body mechanics <input type="checkbox"/> Improper lifting <input type="checkbox"/> Improper loading or placement <input type="checkbox"/> Inattention <input type="checkbox"/> Making safety devices inoperable	<input type="checkbox"/> Operating at improper speed <input type="checkbox"/> Operating equipment without authority <input type="checkbox"/> Rushing <input type="checkbox"/> Servicing equipment in motion <input type="checkbox"/> Was a code of safe practices violated? If so, which one <input type="checkbox"/> Other _____

### Incidence Sequence:

<b>List tasks being performed that led to accident. Who was involved in these tasks?</b>	
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### Findings / Root Causes (Knowledge, ability, motivation, design, maintenance, environment)

<b>List possible causes or actions that may have contributed to the accident or incident:</b>	
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### Corrective Actions Necessary:

<b>What corrective actions need to be taken to prevent another accident (Indicate all that apply)</b>	<input type="checkbox"/> Disciplinary actions <input type="checkbox"/> Improve warning & posting <input type="checkbox"/> Loading or placement training <input type="checkbox"/> Lockout and tagout of energy sources <input type="checkbox"/> Operating procedures posted <input type="checkbox"/> Operator training needed <input type="checkbox"/> Provide better warning <input type="checkbox"/> Replacement or supply safety equipment	<input type="checkbox"/> Safe lifting training <input type="checkbox"/> Specific equipment or task instruction <input type="checkbox"/> Use of necessary personal protective equipment <input type="checkbox"/> Other _____ <input type="checkbox"/> Do these corrective actions need to be made at other sites also?
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### Corrective Actions Taken:

<b>Clarify the specific corrective actions taken, who is responsible and when will they be accomplished:</b>	
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Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SUPERVISOR'S REPORT OF INJURY

## INSTRUCTIONS FOR USE

The form is comprehensive enough to serve as both the Supervisor's Report and the template for an accident investigation. Accident/Incident investigation is a required element for all employers under the Injury and Illness Prevention Program (IIPP). Cal/OSHA notes an employer's investigation procedures, or lack thereof, when following up on complaints or audits. The form has been specifically designed to be able to serve both purposes. It also provides supervisors with a streamlined approach to incident analysis. It is only through thorough incident analysis that effective prevention measures can be implemented.

- The Supervisor's Report of Injury form should be completed whenever an employee reports a work-related incident. Whether the employee requires medical attention is not a prerequisite to completing the form. Even if an employee does not need medical attention, the form should still be completed. The form is designed to capture all relevant elements of an incident, whether comprehensive or simple.
- If the employee does not require medical treatment, the Supervisor's Report is kept on file by the designated person; usually Human Resources (do not send the form to SISC). No further action is required. If an employee does not believe the incident caused an injury that requires medical attention, do not force the employee to seek such treatment.

There is no reason to send an employee to see a physician if not necessary.

There is a common misconception that sending an employee to a physician is required to avoid "liability." There is no such liability being avoided by sending an employee to seek medical treatment when not medically necessary. The Supervisor's Report is the official documentation and is legally sufficient.

- If the incident caused an injury that requires medical attention, provide the employee with the workers' compensation claim form, DWC-1, and follow the claims procedures outlined by SISC I.

In the event an employee reported an incident and originally did not believe medical treatment was necessary, and later believes medical treatment is necessary, the claims process is started at that point. There is no problem, or liability, if this occurs.

If you have any questions about completing the form, or would like assistance in implementing the new form, please contact the SISC Risk Management Services department. Staff are available for in-service, as well as hands-on incident investigation, with district staff.

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

## Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



**WORKERS' COMPENSATION CLAIM FORM (DWC 1)**

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

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

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

**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 División de Compensación al Trabajador al (800) 736-7401 para oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

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

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

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

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

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

**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

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

State of California <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>		Please complete in triplicate (type if possible) Mail two copies to:		OSHA CASE NO.	
				FATALITY <input type="checkbox"/>	
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.		California law requires employers to report within <b>five days</b> of knowledge every occupational injury or illness which results in lost time beyond the date of the incident <b>OR</b> requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within <b>five days</b> of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be <b>reported immediately</b> by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.			
EMPLOYER	1. FIRM NAME			1a. Policy Number	
	2. MAILING ADDRESS: (Number, Street, City, Zip)			2a. Phone Number	
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)			3a. Location Code	
	4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.			5. State unemployment insurance acct.no	
6. TYPE OF EMPLOYER: Private State County City School District <input type="checkbox"/> Other Gov't, Specify: _____					
7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM	
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? Yes No		12. DATE LAST WORKED (mm/dd/yy)	
13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX:		15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? Yes No	
16. SALARY BEING CONTINUED? Yes No		17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)	
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning					
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)			20a. COUNTY		21. ON EMPLOYER'S PREMISES? Yes No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.			23. Other Workers injured or ill in this event? Yes No		
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold					
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.					
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY					
INJURY					
OR					
ILLNESSES					
ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.					
EMPLOYEE					
EVENT					
SECONDARY SOURCE					
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)					
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours			37a. EMPLOYMENT STATUS regular, full-time part-time temporary seasonal		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
EXTENT OF INJURY					
38. GROSS WAGES/SALARY \$ _____ per _____			39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes No		
Completed By (type or print)			Signature & Title		
Date (mm/dd/yy)					
* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.					

EMPLOYEE'S ABILITY TO RETURN TO WORK  
Physician's Work Status Report

Employer/District: \_\_\_\_\_

Employee: \_\_\_\_\_

Job Title: \_\_\_\_\_ Site: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

**To Be Completed By Employee At Time Of Each Examination**

I hereby authorize (name of physician) \_\_\_\_\_, or any other physician(s) involved in my care, to release information regarding my physical condition relating to the injury/illness associated with the date of injury listed above to SISC Safety and Loss Control department, my employer (as indicated above), and/or my employer's designee responsible for assessing work assignment possibilities. The information disclosed pursuant to this form shall be used solely for the purpose of evaluating my ability to perform assigned work tasks. This authorization shall become effective immediately upon my signature and shall expire on the re-evaluation date listed below (E.). I understand I have a right to receive a copy of this authorization.

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Date)

To Be Completed By Physician \_\_\_\_\_ First Aid \_\_\_\_\_ This is not a work related injury

A. Diagnosis: \_\_\_\_\_

B. Can patient return to work without restrictions? \_\_\_ Yes \_\_\_ No (If "No", please complete remainder of this form)

C. Please detail the specific work restrictions prescribed for the patient. **Your detailed description of the patient's restrictions will enable the employer to make appropriate placement decisions without the need for potential telephonic clarification.** Note that the employer may have many options regarding light duty assignments, which will allow the patient to rehabilitate and remain a productive member of the district without risk of re-injury. Unless otherwise indicated, the restrictions will be in effect until the re-evaluation date indicated below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Are: Mediations \_\_\_\_\_ Braces/Splits \_\_\_\_\_ Prescribed? If "Yes", please explain:

\_\_\_\_\_  
\_\_\_\_\_

E. Patient's Re-Evaluation Date: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return completed form to employee. Employee will return to district.