

**CHAPTER 10 HOW TO FILE A WORKERS'
COMPENSATION CLAIM
&
REPORTING ON-THE-JOB INJURIES
& ILLNESSES**

HOW TO FILE A WORKERS' COMPENSTATION CLAIM & REPORTING ON-THE-JOB INJURIES & ILLNESSES

I. Purpose

An on-the-job injuries and illnesses reporting program is established to provide a means for an individual employee and his or her supervisor to report an incident that may have resulted in a work-related injury and/or illness.

II. Policy

All work-related injuries and illnesses will be reported by employees to their supervisors. Forms provided to the department by Risk Management will be given to the injured worker. The injured worker may complete the form and return it to his or her supervisor;

Accidents alleged to have occurred on the job will be evaluated by the supervisor to determine the cause(s) and to establish steps or processes to take place which will prevent similar accidents from taking place in the future;

All employees who suffer work-related injuries or illnesses will be offered medical treatment from their pre-designated treating physician; or, if no pre-designation card on file in Risk Management, Redding Occupational Medical Center (ROMC); or Burney Health Center (Burney area). Supervisors shall phone Risk Management to report any injury/illness requiring treatment or when the employee has completed and returned the claim form;

At the end of every pay period, the department Payroll Clerk will report any lost work days incurred by employees who have suffered work-related injuries/illnesses, and this report will be sent to Risk Management on the Lost Time Report;

All employee injury/illness reports will be reviewed monthly by the department head or his assistant to identify management changes necessary to minimize accidents and injuries.

III. Reporting Procedures

A. Employee

1. When an Employee has an incident that may have resulted or resulted in a work-related injury and/or illness, the Employee will report to his/her supervisor as soon as they are physically capable of doing so. If it is an emergency, call 911.
2. If the Employee does **not need** (or request) medical treatment he/she must read and follow the "Declination of Medical Treatment (DMT) Instructions" form, and complete the Employee section of the "Incident Report Declined Medical Treatment," and the "Declination of Medical Treatment" forms with his/her supervisor within 1 working day of the incident.
3. If the Employee has an injury or illness related to his/her job and wishes to file a workers compensation claim he/she must follow the instructions provided on the form titled "Employee Instructions For Completion of DWC Form 1."
4. If the Employee chooses to file a workers' compensation claim, the Employee should

complete the Employee portion of the DWC Form 1 “Employee’s Claim for Workers’ Compensation Benefits,” keep the pink copy and provide the original to his/her supervisor, sign the lower portion of the “Claim Form Packet Instructions” where indicated and check the box that indicates his/her treatment location, and give the original to his/her supervisor. The employee takes the pink copy of the DWC Form 1 to Redding Occupational Medical Center or to his/her pre-designated personal physician.

B. Supervisor

1. The Supervisor must follow the “Supervisor’s Incident/Injury Checklist” instructions to ensure that all appropriate and necessary actions have been taken.
 - a. If it is an emergency, call 911.
 - b. **Call Cal/OSHA at 1-800-963-9424 when there is a Serious Injury/Illness/Death.** Then contact Risk Management at 225-5141 and/or by FAX at 225-5251. (See Chapter 29 for complete policy).
2. When an Employee has any incident that **may have resulted or resulted** in a work-related injury and/or illness, the Supervisor must complete the “Shasta County Risk Management Supervisor’s Incident Report” following the instructions provided in the “Instructions for Completing Supervisor’s Incident Report” sheet, and submit the Supervisor’s signed copy of the Shasta County Risk Management Supervisor’s Incident Report” form to Risk Management via fax, email or inter-office mail within 1-working day of the incident. The Department must forward the original completed form to Risk Management as soon as possible after the Department Head or his/her designee signs the form.
3.
 - a. If it is not an emergency ask the Employee if they want (non-emergency) medical treatment. If **NO**, complete the Declination of Medical Treatment Form with the Employee following the instructions on the “Declination of Medical Treatment Checklist.” Complete the Shasta County Risk Management Supervisor’s Incident Report form. Keep a copy of both forms for your records.
 - b. The Supervisor and the Employee complete the “Incident Report Declined Medical Treatment” form following the instruction provided on the form.
4. If **YES**, give the employee the claim form packet and together with the employee complete the **Claim Form (DWC-1)**, and distribute forms according to the “Claim Form Packet Instructions.” Send or take the employee to the clinic or pre-designated physician for treatment. Complete the Shasta County Risk Management Supervisor’s Incident Report form.

Serious Injury/Illness/Death

In accordance with §342(a), Title 8, California Code of Regulations, it is necessary to immediately report to the nearest district Office of the Division of Occupational Safety and Health any serious injury or illness, or death, of an employee occurring in a place of employment or in connection with any employment.

Cal/OSHA Consultation Toll-Free Number

1-800-963-9424

Then contact:

Shasta County Risk Management

1450 Court Street, Room 348

Redding, CA 96001

(530) 225-5141

Fax (530) 225-5251

Serious injury or illness is defined as "any injury or illness occurring in a place of employment or in connection with any employment which requires inpatient hospitalization for a period in excess of 24 hours for the other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement, but does not include any injury or illness or death caused by the commission of a Penal Code violation, except the violation of Section 385 of the Penal Code, or an accident on a public street or highway." *Chapter 3.2 of California Occupational Safety and Health Regulations (CAL/OSHA), Subchapter 1, regulations of the Director of Industrial Relations, article 1, Definitions Under California Occupational Safety and Health Act of 1973. §330.*

SHASTA COUNTY RISK MANAGEMENT

Supervisor's Incident/Injury Checklist

When an Employee has an incident that may have resulted in a work-related injury, the Employee will report to his/her Supervisor. The Supervisor must follow this checklist to ensure that all appropriate and necessary actions have been taken.

- If it is an emergency, call 911.
- If it is not an emergency, ask the Employee if they want (non-emergency) medical treatment.
- If **NO**, complete the *Declination of Medical Treatment Form* with the Employee. Please keep this form in case the employee decides to seek treatment at a later date. Complete Supervisor's Incident Report
- If **YES**, give the employee the claim form packet and together with the employee complete the *Claim Form (DWC-1)*, and distribute forms according to Packet instructions. Send or take the Employee to the clinic or pre-designated physician for treatment.

FOLLOW UP OVERVIEW:

After each medical appointment, the Employee will provide his/her Supervisor with Work Restrictions provided by the physician. The Supervisor will take appropriate action depending on the Employee's work status:

- A. If the Employee is released to Usual & Customary position (full duty):**
 - o The Supervisor will advise the Employee to return to work.
 - o The Employee will return to the Treating Physician for any indicated follow-up appointments. Attempts should be made to schedule any appointments around the Employee's work shifts.
- B. If the Employee has any work restrictions:**
 - o The Supervisor, (with support as needed from Personnel and/or departmental upper management), will facilitate an interactive accommodation meeting with the Employee to determine if an appropriate temporary transitional assignment is available. If an assignment is available, all parties will review and sign the **Work Accommodation Meeting** agreement. The supervisor shall forward a copy of the agreement to Risk Management. Call Support Services Director/Assistant Director, with any questions or for assistance with this agreement.
 - o If a Transitional Assignment is not available, the Supervisor will telephone Risk Management immediately.
- C. If the Employee is Totally Temporarily Disabled:**
 - o If the Employee is unable to return to any assignment within the department, please inform Risk Management as well as the appropriate department management and Personnel. An accommodation meeting may be held with Personnel to determine if restrictions may be accommodated within other County departments. If not, then FMLA/CFRA documents may be required at this time. In addition, as updates are received regarding work restrictions, it may be necessary to communicate with the injured worker to discuss work status.
- D. If the Employee is Permanently Disabled:**
 - o If the Employee becomes permanently unable to return to the Usual & Customary position, the Supervisor will contact Risk Management who will initiate an interactive process with the Employee to identify a Modified or Alternative placement within the County as available.

(This page can be laminated for use as a convenient reference tool in an office or off-site environment. Include the following page on the back of this laminated page for easy reference in the event that OSHA needs to be notified.)

DECLINATION OF MEDICAL TREATMENT (DMT) INSTRUCTIONS

This packet is for use ONLY if the Employee DECLINES medical treatment at time of injury.

If the employee is seeking treatment from either a pre-designated physician or the county designated medical facility they must complete a Workers' Compensation Claim Form – DWC-1.

Employee:

- Complete and sign the top portion of the **Declined Medical Treatment-Incident form**.
- Complete and sign the **Declination of Medical Treatment form**.

Supervisor and/or Department Workers' Compensation Coordinator:

- **Review and sign the *Declination of Medical Treatment (DMT) form***.
- **Complete and sign the bottom portion of the *Incident Report***.
- **Complete and sign the *Supervisor's Incident Report***.
- **Have each witness complete and sign a *Witness of Incident Statement form***.
- Send completed "original" Declination of Medical Treatment form, supervisor report and witness statements to your department's Workers' Compensation Coordinator for review.
- Retain a copy of the Declination of Medical Treatment form, supervisor report and witness statements in your department's personnel medical only folder.
- After all documents have been reviewed by the department's Workers' Compensation Coordinator, all original documents are to be forwarded to Risk Management.
- No further action is necessary at this time.

If the employee needs or requests medical treatment in the future:

- Employee and Supervisor complete a Workers' Compensation claim packet including the DWC-1 claim form.
- Include a copy of the Declination of Medical Treatment forms that were completed prior for the same incident.

Contact Risk Management at (530) 225-5141, with any questions related to the declination of medical treatment forms process.

Employee &
Supervisor
Complete

SHASTA COUNTY RISK MANAGEMENT

INCIDENT REPORT AND CHECKLIST: DECLINED MEDICAL TREATMENT

This form should be completed ONLY if the Employee does not need (or request) medical treatment. If the Employee will go to either a designated medical facility or the pre-designated physician, the Claim Form Packet must be completed instead of this Declaration of Medical Treatment Report.

"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 is guilty of a felony." *This notice has been approved by the Administrative Director of the Division of Workers' Compensation (California Labor Code Section 5401.7)*

EMPLOYEE COMPLETE THIS SECTION OF THE FORM

Use the back of this form and additional sheets as necessary to obtain and record all pertinent information

EMPLOYEE NAME:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
JOB TITLE:		DEPARTMENT:	
INCIDENT DATE:	TIME OF INCIDENT:	LOCATION OF INCIDENT (building location, department, etc.):	
DATE REPORTED:	TIME BEGAN WORK:	INCIDENT REPORTED TO:	
BODY PART INJURED AND NATURE OF INJURY (e.g., puncture to right foot, strained left wrist, cut on right index finger, tick bite on left arm, burn, etc.):			
INJURY SOURCE (e.g., wet pavement, jack hammer, keyboard, etc.):			
HOW INJURY OCCURRED (struck by ..., fell from ..., exposed to ..., etc.):			
EMPLOYEE'S STATEMENT OF WHAT OCCURRED (Include as much detail as possible such as activity being performed, objects carried, equipment used, hazardous conditions, etc.):			
<input type="checkbox"/> In my opinion, I am not in need of any medical treatment at this time. OR In my opinion, I have received sufficient on-site first aid care in the form of:			
<input type="checkbox"/> Application of antiseptics		<input type="checkbox"/> Treatment of first-degree burn(s)	
<input type="checkbox"/> Application of bandage(s)		<input type="checkbox"/> Use of elastic bandage(s)	
<input type="checkbox"/> Use of nonprescription medications		<input type="checkbox"/> Application of hot or cold compress(es)	
<input type="checkbox"/> Removal of foreign bodies not embedded in eye (only irrigation required)			
<input type="checkbox"/> Removal of foreign bodies from wound (uncomplicated procedure, for example, using tweezers)			
<input type="checkbox"/> Application of ointments to abrasions to prevent drying or cracking			
WHO WITNESSED THE INCIDENT?			
<input checked="" type="checkbox"/> The above information is true and correct to the best of my knowledge. <input checked="" type="checkbox"/> I understand that I am not filing a Workers' Compensation claim at this time. I do not choose to complete the DWC Form 1 "Employee's Claim for Workers' Compensation Benefits" at this time. If I am in need of medical treatment in the future related to this incident, I will immediately inform my Supervisor and complete a Claim Form Packet including the DWC Form 1.			
EMPLOYEE'S PRINTED NAME AND SIGNATURE:			DATE:

SUPERVISOR COMPLETE THIS SECTION OF THE FORM

MEDICAL TREATMENT (NOTE: If the Employee needs/requests medical treatment from a physician, complete the Claim Form Packet)			
<input type="checkbox"/> EMPLOYEE DECLINED MEDICAL TREATMENT			
<input type="checkbox"/> EMPLOYEE RECEIVED MINOR FIRST AID ON-SITE AS NOTED ABOVE.			
SUPERVISOR (Print Name):		TITLE	DEPARTMENT HEAD (OR DELEGATE)
SIGNATURE:		DATE	SIGNATURE
TELEPHONE:		DATE	

Initial Distribution: Department Supervisor Initiate incident investigation in accordance with the Injury & Illness Prevention Program (IIPP)
WCC: Risk Management

INSTRUCTIONS FOR COMPLETING SUPERVISOR'S INCIDENT REPORT

- The Supervisor's Incident Report 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." *Reference: Section 14300.29 (b)(6)-(10). When a work connected fatality or hospitalization occurs, the State of California requires the employer to immediately (within 8 hours) contact Cal/OSHA Area Office to report the incident. Reference: General Industry Safety Orders Section 342 Reporting Work Connected Fatalities and Serious Injuries*
- The purpose of the Supervisor's Incident Report form is to get the specific facts; the who, what, why, where, when and how related to the incident and use the information to prevent future injuries in addition to meeting recordable injury reporting requirements.
- Within 7-days of receiving information that a work related injury or illness has occurred, or a work-related injury where the employee declined medical treatment, this form must be completed. The sooner you complete the form, the more accurate your report will be.
- Investigate the injury or incident, then complete and submit the form even if the employee declines medical treatment.
- Unsafe Act – If you indicate there was no unsafe act, please explain why. Attach additional pages if necessary.
- If an unsafe act is checked, you must complete the preventive action(s) to be taken. If “other” is checked, you must describe what the preventive action(s) is. Attach additional pages if necessary.
- Unsafe Conditions – If you indicate there was no unsafe condition(s), please explain why. Attach additional pages if necessary.
- If an unsafe condition is checked, you must complete the preventive action(s) to be taken. If “other” is checked, you must describe what the preventive action is. Attach additional pages if necessary.
- Complete the Safety Training questions below the Lost-time certification section. If left blank it will be returned for completion. “N/A,” or not applicable is not acceptable. If you feel no safety training is necessary please explain why. Attach additional pages as necessary.
- Distribution: Submit the completed form to Risk Management after signing it via email to jdjohnson@co.shasta.ca.us, or via fax to 530-225-5251. If you do not have email or fax access, send a copy inter-office mail to Risk Management at CH-202. The original should be forwarded via inter-office mail to Risk Management after the department head or the designee also signs the form. Check with your department for any departmental distribution policies.

Supervisor Complete

SHASTA COUNTY RISK MANAGEMENT SUPERVISOR'S INCIDENT REPORT

EMPLOYEE NAME: Gender: [] FULL TIME [] PART TIME
JOB TITLE: DEPARTMENT: WORK PHONE NO.

INVESTIGATION Interview the Employee and investigate the reported incident and then complete the following: Use the back of this form and additional sheets as necessary to obtain and record all pertinent information

[] Check this box if a Declination of Medical Treatment Packet was previously completed for this same incident.
INCIDENT DATE: TIME OF INCIDENT: LOCATION OF INCIDENT (building location, department, etc.):
DATE REPORTED: TIME BEGAN WORK:

DESCRIPTION OF INCIDENT - Interview the Employee and any witnesses, and determine how the incident occurred and what the employee was doing prior to incident.
Has a similar incident occurred in the past? Yes [] NO [] Have you contacted Fleet [] Facilities []

DESCRIPTION OF THE INJURY- Body part injured, type of injury, etc.

INJURY SOURCE- Investigate and comment on the source of the injury. For example, if the employee has a laceration caused by a tool, examine the tool and indicate whether it appears to be in proper condition, is properly guarded, etc.

HOW INJURY OCCURRED - Investigate how the injury occurred, and determine whether it was caused by an unsafe act or an unsafe condition, or both. Use the sections below to detail the nature of the act(s) or condition(s) that may have caused or contributed to the incident.

UNSAFE ACT (IF ANY) [] IMPROPER BODY POSITIONING [] UNSAFE WORK METHOD [] HURRIED OR DISTRACTED WORK [] UNSAFE USE OF EQUIPMENT [] FAILURE TO USE PROPER PERSONAL PROTECTIVE EQUIPMENT (Specify): [] IMPROPER LIFTING TECHNIQUE [] NO UNSAFE ACT [] OVEREXERTION [] OTHER:
UNSAFE CONDITION (IF ANY) [] DEFECTIVE EQUIPMENT [] IMPROPER LIGHTING [] UNGUARDED EQUIPMENT [] INADEQUATE VENTILATION [] TRIP/SLIP HAZARD ON FLOOR [] UNFORESEEN HAZARD/WEATHER [] UNSAFE ARRANGEMENT OF ITEMS [] OTHER: [] IMPROPER DRESS OR APPAREL [] NO UNSAFE CONDITION
PREVENTIVE ACTION(S) TO BE TAKEN [] PROVIDE ADDITIONAL TRAINING [] DISCIPLINE EMPLOYEE [] MODIFY/DISCONTINUE WORK PRACTICE [] OTHER:
PREVENTIVE ACTION(S) TO BE TAKEN [] ELIMINATE CONDITION [] REPAIR CONDITION [] REPORT CONDITION TO: [] OTHER:

LOST-TIME CERTIFICATION FROM SUPERVISOR

Did employee lose at least one day of work after injury? Yes [] NO [] Did employee receive full wages for last day worked? * Yes [] NO []
If "Yes" Last day worked: _____ Date claim form provided to employee _____
Has employee returned to work? Yes [] NO [] Name of clinic, physician, or hospital: _____
Date employee returned to work: _____ * Indicate if sick leave was used: Yes [] NO []

What safety training did the employee receive in the past 12 months that is specifically related to this incident?
What type of safety training will be necessary?

SUPERVISORY SIGNATURES

SUPERVISOR (Print Name): TITLE DEPARTMENT HEAD (OR DELEGATE)
SIGNATURE: DATE SIGNATURE DATE
TELEPHONE:

WITNESS STATEMENT If there was a witness to this incident, they should attach a detailed statement regarding their observation of the incident, and sign below.

WITNESS STATEMENT (use back of page if necessary):
NAME: SIGNATURE: DATE:

EMPLOYEE INSTRUCTIONS FOR COMPLETION OF DWC FORM 1

If you have an illness or injury related to your job and you wish to file a workers' compensation claim and receive benefits, you may do so by completing the DWC Form 1. There is no requirement that you do so, the choice is yours.

To file a claim for workers' compensation benefits, you need to do the following:

1. Report your illness or injury to your supervisor and explain that you wish to file a workers' compensation claim.
2. The supervisor will provide you with a workers' compensation claim packet. Sign the bottom of the instructions page and indicate if you went to the designated medical facility or to your predesignated physician. Your supervisor will date and initial Line 13 of the DWC Form 1 and ask you to sign the goldenrod copy. He/She will keep the goldenrod copy as an acknowledgment that you have been given the DWC Form 1. When completing the DWC Form 1, either type or press firmly, using a ballpoint pen on a hard surface.
3. Fill in all the blanks in the upper portion of the DWC Form 1, and complete the following forms:
 - a. "Authorization for Use or Disclosure of Protected Health Information" (4 pages)
 - b. "Medical Mileage Expense Form", (goldenrod form) if applicable.
4. Return the completed DWC Form 1 and Authorization for Use or Disclosure of Protected Health Information" (4 pages) to your supervisor immediately if you wish to file a claim.
5. Be sure to tell the supervisor:
 - a. Your name
 - b. Date and time of illness/injury
 - c. Description of your illness/injury
 - d. If medical attention was sought prior to reporting illness/injury
 - e. Who provided medical treatment
 - f. Names of anyone who witnessed the incident
6. The Supervisor will give you the pink copy of the DWC Form 1 to take with you to Redding Occupational Medical Center or your personal physician (only if you have a personal physician card on file with Risk Management), when you seek medical treatment.
7. When receiving treatment, be sure to follow the doctor's instructions.

SUPERVISOR'S INSTRUCTIONS FOR PROCESSING EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

The **workers' compensation claim** packet contains:

- 1) Claim Form Packet Instructions
- 2) 5-part NCR DWC-1 "Employee's Claim for Workers' Compensation Benefits" form.
- 3) Supervisor's Incident Report
- 4) Letter to Injured Worker & List of Authorized Pharmacies
- 5) "Facts for Injured Workers" pamphlet
- 6) "Facts About Workers' Compensation" pamphlet
- 7) Release of Medical Information (2 pages)
- 8) Medical Mileage Expense Form
- 9) Emergency Room Usage Memorandum
- 10) Industrial Leave Policy (Personnel Rule 12.02)
- 11) Temporary Transitional Work Accommodation Agreement Instructions
- 12) FMLA Leave Notification
- 13) Proof of Service by Mail

Step 1. When an employee reports a work-related injury or illness, the Supervisor shall **immediately**:

- a. Provide the employee with the claim form packet and have the employee sign the bottom of the instruction page.
- b. Date and initial line 12 only of the DWC-1 form in the packet, leaving all other information blank. When filling out the DWC-1 form, either type or press firmly, using a ballpoint pen on a hard surface.
- c. Have employee sign and date the bottom of the goldenrod copy of DWC-1 form (acknowledges receipt).
- d. Keep the goldenrod copy and retain it in a file.
- e. Remove supervisor's Incident Report and give packet containing DWC-1 form, pamphlets, etc., to employee for completion.
- f. Ask the employee to complete the employee (upper) portion of the DWC-1 form, as well as:
 - 1) Release of Medical Information
 - 2) Application for Reimbursement of Mileage or Other Expenses (buff form).

The option is the employee's choice to complete the DWC-1 form. DO NOT force the employee to complete the form. The employee returns the signed DWC-1 form only if he/she seeks medical treatment.

Step 2. If the employee returns the completed DWC-1 form to the supervisor, the supervisor completes the employer (lower) section, keeping the original and yellow copy, giving the pink copy to the employee to take with him/her to his/her medical provider.

- Step 3. a. The supervisor completes the Supervisor's Incident Report. On the Supervisor's Incident Report form, be sure to indicate if full wages were paid for the day of injury, as well as if sick leave was used
- b. Forward all materials to the department personnel technician.
- c. The personnel technician will type an Employer's Report of Occupational Injury or Illness (OSHA Form 5020) and keep a copy of the DWC-1 form.
- d. The personnel technician will send the original of the DWC-1 form (white sheet), along with the Supervisor's Incident Report and OSHA Form 5020 immediately to Risk Management.

Step 4. On the same day of the injury, the employee's immediate Supervisor shall call Risk Management at 225-5141 and state they are reporting a workers' compensation injury. The Supervisor shall be prepared to provide the following information:

- a. The supervisor's name (yours, if it is the case), department and phone number
- b. Injured worker's name
- c. Date and time of the injury
- d. Brief description of injury (example - cut finger, left hand)
- e. Did employee get medical attention?
- f. Who rendered the medical attention? (ROMC, personal physician if pre-designated, or other)
- g. Names of any known witnesses
- h. Will worker be disabled beyond date of injury? (if known)
- i. Was DWC-1 form given to the injured worker (or was it mailed)?

Note: In case of serious injuries, (please refer to Chapter 29 to determine if the injury needs to be reported to OSHA), if the employee is unavailable to complete the claim form within one working day, fill in the Employer section of the DWC-1 form, leaving Lines 11 and 13 blank; tear off the goldenrod copy for your records, complete the "Proof of Service by Mail" (attached), and mail the packet containing the employee instructions, pamphlets, DWC-1 form, release of medical information, and mileage forms to employee's home address. Instruct the injured worker to return the completed form as soon as possible to the department if they wish to file a claim. Hand deliver the Proof of Service By Mail and the Supervisor's Incident Report Form to the departmental personnel technician. (Personnel technician: The DWC-1 form, goldenrod copy, is for your records. Make a photocopy of the Proof of Service by Mail and Supervisor's Accident Evaluation form for your records. Send a photocopy of the DWC-1 form goldenrod copy, the original Proof of Service by Mail, the Supervisor's Incident Report form, and the Employer's Report of Occupational Injury/Illness form (OSHA 5020) immediately to Risk Management. Also, immediately telephone Risk Management with the information outlined in Step 4.)

Volunteers: Please refer to the County Administrative Manual, 3-140, to determine if the individual would be covered under workers' compensation or accident medical insurance.

Claim Form Packet Instructions

An injury or illness has occurred. Follow all instructions to complete this packet prior to medical treatment. If the Supervisor takes the Employee to a medical facility, then the packet can be completed there. If there is an emergency call 911, and then complete the packet as soon as possible after treatment.

Employee:

- Complete the Employee portion of the *DWC Form 1 “Employee’s Claim for Workers’ Compensation Benefits.”*

Supervisor:

- Complete the Employer portion of the *DWC Form 1 “Employee’s Claim for Workers’ Compensation Benefits.”*
- Complete the *Supervisor Incident Report.*

Distribution of forms:

- Employee: Keep *the pink copy of DWC-1.*
- Supervisor: Send original DWC-1 and Supervisor’s Report to your Department Personnel Technician for completion of the OSHA 5020
- Department Personnel Technician – forward all originals to Risk Management Immediately

Employee: Sign here to acknowledge receipt of the Claim Form Packet

EMPLOYEE’S SIGNATURE

Check to indicate treatment location:

- Designated Medical Facility Pre-designated Physician



Shasta County

SUPPORT SERVICES - RISK MANAGEMENT

1450 Court Street, Room 348
Redding, CA 96001-1676
(530) 225-5141
(530) 225-5251 FAX
California Relay Service at 711 or 800 735-2922

Dear Injured Worker:

In order to comply with California Labor Code §5402, Employer's Notice to Employee regarding on-the-job injury/illness, we are enclosing the following for your assistance and information:

1. "Facts About Workers' Compensation" pamphlet.
2. "Medical Mileage Expense" form. Shasta County Risk Management will reimburse you for mileage to your treating physician and for therapy appointments.
3. "Authorization for Use or Disclosure of Protected Health Information" (4 page form). This release is necessary because a physician or chiropractor will not release medical reports necessary for determination of your claim without your written permission. Please sign and return to Risk Management when filing a claim.
Please complete and return to Risk Management when filing a claim.

Also, in order to comply with California Labor Code, Administrative Rules of the Division of Industrial Accidents, §9782, Shasta County Risk Management is given medical control for the first thirty (30) days from the date of an on-the-job injury/illness, unless the employee has notified Shasta County Risk Management, prior to the injury, that he/she has a pre-designated treating physician. Any medical treatment obtained from any source other than your pre-designated treating physician, (card on file at Risk Management Office prior to injury), or Shasta County's designated medical facility will be at the expense of the employee. The designated medical facilities are:

Redding Occupational Medical Center
1710 Churn Creek Road
Redding, CA 96002-0236
(530) 646-4242

Burney Health Center
20641 Commerce Way
Burney, CA 96013
(530) 335-5457

HOSPITALS:

Shasta Regional Medical Center
1100 Butte Street
Redding, CA 96001
(530) 244-5400

Mercy Medical Center
2175 Rosaline Avenue
Redding, CA 96001
(530) 225-6000

Mayer's Memorial
43563 Highway 299 East
Fall River Mills, CA 96028
(530) 336-5511

If you have any questions, please don't hesitate to contact our office at (530) 225-5141.

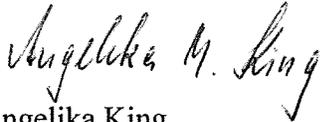
Sincerely,



Char Wilburn
Workers' Compensation Analyst III



Steve Taylor
Workers' Compensation Analyst III



Angelika King
Workers' Compensation Adjuster II

CW/ST/AK:jf

Enclosures

10/19/16

AUTHORIZED PHARMACIES FOR ON THE JOB INJURY/ILLNESS PRESCRIPTIONS

NAME	ADDRESS	CITY	STATE	ZIP
COSTCO PHARMACY	1300 DANA DR	REDDING	CA	96003
COTTONWOOD DRUG	20635 GAS POINT RD	COTTONWOOD	CA	96022
FERRYS PHARMACY	2940 EAST ST	ANDERSON	CA	96007
LIMS FAMILY PHARMACY	1035 PLACER ST STE 110	REDDING	CA	96001
CVS DRUG STORE	3375 PLACER ST	REDDING	CA	96001
CVS DRUG STORE	1060 E CYPRESS AVE	REDDING	CA	96002
OMNICARE REDDING	5200 CHURN CREEK RD # A	REDDING	CA	96002
OWENS HEALTHCARE	1002 PLACER ST	REDDING	CA	96001
OWENS HEALTHCARE	317 LAKE BLVD # 8	REDDING	CA	96003
OWENS PHARMACY	2510 AIRPARK DR # 204	REDDING	CA	96001
OWENS PHARMACY	2025 COURT ST # A	REDDING	CA	96001
OWENS PHARMACY	2025 COURT ST # B	REDDING	CA	96001
OWENS PHARMACY	2920 CHURN CREEK RD	REDDING	CA	96002
OWENS PHARMACY	2995 EAST ST	ANDERSON	CA	96007
RALEY'S DRUG CENTER	201 LAKE BLVD	REDDING	CA	96003
RITE-AID PHARMACY	1801 EUREKA WAY	REDDING	CA	96001
RITE-AID PHARMACY	6424 WESTSIDE RD	REDDING	CA	96001
RITE-AID PHARMACY	975 E CYPRESS AVE	REDDING	CA	96003
RITE-AID PHARMACY	2641 BALLS FERRY RD	ANDERSON	CA	96007
RITE-AID PHARMACY	5350 SHASTA DAM BLVD	SHASTA LAKE	CA	96019
RITE-AID PHARMACY	37435 MAIN ST	BURNEY	CA	96013
SAFEWAY PHARMACY	2275 PINE ST	REDDING	CA	96001
SAFEWAY PHARMACY	1070 E CYPRESS AVE	REDDING	CA	96002
SAFEWAY PHARMACY	2601 BALLS FERRY RD	ANDERSON	CA	96007
SAFEWAY PHARMACY	1630 MAIN ST	BURNEY	CA	96013
SHOPKO PHARMACY	55 LAKE BLVD	REDDING	CA	96003
TARGET PHARMACY	1280 DANA DR	REDDING	CA	96003
WALGREENS	980 E CYPRESS AVE	REDDING	CA	96002
WALGREENS	1205 COURT ST	REDDING	CA	96001
WALGREENS	115 LAKE BLVD E	REDDING	CA	96003
WALMART PHARMACY	1515 DANA DR	REDDING	CA	96002
WALMART PHARMACY	5000 RHONDA RD	ANDERSON	CA	96007
RITE AID PHARMACY	9390 DESCHUTES RD	PALO CEDRO	CA	96073
OWENS PHARMACY	9387 DESCHUTES RD 1	PALO CEDRO	CA	96073



Shasta County Risk Management
1450 Court Street, Room 348
Redding, CA 96001
Phone: (530) 225-5141
Fax: (530) 225-5251

Authorization for Use or Disclosure of Protected Health Information (PHI)

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

I authorize: _____ Please see attached

(Name of Person and/or Facility which has information)

(Street Address, City, State, Zip Code)

To release health information to:

Legal Photocopy Service representing Shasta County Risk Management and/or attorney of record

(Specify Name/Title of Person and/or Facility to receive health information)

2700 Eureka Way, Redding, CA 96001

(Street Address, City, State, Zip Code)

Please specify the health information you authorize to be released:

Medical Records

Mental Health (other than Psychotherapy notes)

Type(s) of health information: Any and all medical records

Date(s) of treatment: Any and all dates of service

The following information will not be released unless you specifically authorize it by marking the relevant box(s) below:

I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).

I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

The purpose of this release is for (check one or more):(State reason): Legal Review and/or a claim filed and/or a lawsuit filed**NOTICE**

Many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to:

Shasta County Risk Management, 1450 Court Street, Room 348, Redding, CA 96001

Department name and Mailing Address

This revocation will take effect when addressee receives it, except to the extent addressee or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this Authorization expires One year after signing
(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

Print Name

Signature (Patient, Parent, Guardian)

Date

Relationship to Patient

To the Employee: Please list the name and addresses of **any and all** doctors, hospitals, and chiropractors you have seen. This should include the name of your family doctor, any visits made to hospitals and clinics (**even emergency room visits**) and the names of any other physicians or chiropractors you have seen. Please be certain to indicate if any treatment was received under another name, such and a maiden name. **Please list the above whether or not it is related to this injury.**

YOUR FAMILY DOCTOR:

ANY OTHER PHYSICIANS:

1. _____

HOSPITALS AND CLINICS:

1. _____

2. _____

2. _____

3. _____

3. _____

CHIROPRACTORS:

1. _____

2. _____

In addition to the records of the physicians you have identified and released above, you are required to notify us of any and all physicians with whom you have treated by whose records you decline to release with this authorization.

Injured Worker's Name/Nombre de la lesionada

Claim Number/Numero de Reclamo

SUPPORT SERVICES - RISK MANAGEMENT

1450 Court Street, Room 348
 Redding, CA 96001-1676
 (530) 225-5141
 (530) 225-5251 FAX
 California Relay Service at 711 or 800 735-2922

MEMORANDUM

TO: All County Employees
 FROM: Shasta County Risk Management
 DATE: 08/16/16
 SUBJECT: HOSPITAL EMERGENCY ROOM USAGE FOR ON-THE-JOB INJURIES/ILLNESSES

This memo is a reminder that the emergency room is for EMERGENCIES ONLY. This also applies to any on-the-job injury/illness. Please use the emergency room only when your injury/illness is life threatening or when a delay in treatment would decrease the likelihood of maximum recovery. Examples of appropriate emergency treatment are: fractures, extensive blood loss, loss of consciousness, intolerable levels of pain, excessive swelling, or poisoning.

Examples of non-emergency treatment are: minor cuts not requiring sutures, splinters, minor burns (first degree), minor abrasions, bruises and sprains. Obviously, if the injured body part is extremely painful or swollen, you should seek emergency treatment. If not, you should go to Redding Occupational Medical Center, located at 1710 Churn Creek Road, behind Dairy Queen in Redding, Burney Health Center in the Burney/Fall River area, or your pre-designated treating physician if you have pre-designated one and the card is on file at Risk Management prior to the time of injury. Redding Occupational Medical Center (ROMC) is open with the following hours: Monday through Friday, from 8:00 a.m. to 6:00 p.m. ROMC is closed on the following major holidays: New Year's Day, Presidents Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas. Please, do not wait until your shift is over when Redding Occupational Medicine is closed and then seek treatment in a hospital emergency room. Tetanus shots, if needed, can wait 48 hours from the time of injury.

If your injury is serious, go to Mercy Medical Center, Shasta Regional Medical Center, or Mayers Memorial emergency room for treatment. If the injury occurs after hours or on the weekend and can be treated with simple first-aid, do so, and then see your pre-designated treating physician, ROMC, or Burney Health Center first thing in the morning or on Monday. Using the emergency room for first-aid treatment incurs unnecessary costs, can delay treatment to others who have a serious injury, and may not be paid by Risk Management unless it meets the criteria specified in paragraph one.

Remember, unless you have pre-designated a treating physician who has your records and has treated you in the past PRIOR to your injury/illness, and unless this card is on file with Risk Management, you must go to ROMC for treatment during the first thirty (30) days after the injury/illness. If you seek treatment elsewhere, (except in the case of an emergency) you may be liable for the expenses incurred. Your help in complying with these standards will be appreciated.

COUNTY OF SHASTA		Number
ADMINISTRATIVE MANUAL		3-130
SECTION:	Risk Management	Industrial Leave
INITIAL ISSUE DATE:	August 18, 1992	
LATEST REVISION DATE:	July 13, 2012	
PAGE NO:	Page 1 of 2	

PURPOSE

To provide full wage or salary compensation for an employee who is absent from work as a result of an industrially related illness or injury where Section 4652 of the Labor Code is applicable. (This policy is also in the Personnel Rules as Section 13.3.)

POLICY

For an employee to receive industrial leave, he or she must apply for workers' compensation benefits and supply supportive medical evidence that there was an industrial injury or disease contracted in the course and scope of employment, which prevents the employee from performing his or her duties.

Such compensation shall be applied to wage loss for the date of injury and subsequent workdays lost during the thirty (30) days immediately following the date of injury. In no event shall compensation exceed 32 hours.

On the fourth consecutive calendar day following the date of injury or illness, provided the employee remains off work, temporary disability benefits will then be paid in accordance with Labor Code §4653.

Beginning with the date temporary disability benefits are applicable (Labor Code §4653) and every day of covered absence thereafter, in the following order, an employee's compensatory time off, sick leave, administrative leave, and vacation may be charged to assure that, when added to temporary disability benefits paid under workers' compensation, the employee will receive as near to but not exceeding his or her full salary or wage. The employee, at his or her option, may elect any order of application of compensatory time, sick leave, administrative leave, vacation, or none of the preceding benefits if he or she notifies Risk Management in writing within 14 days of the date of injury.

COUNTY OF SHASTA		Number
ADMINISTRATIVE MANUAL		3-130
SECTION:	Risk Management	Industrial Leave
INITIAL ISSUE DATE:	August 18, 1992	
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PAGE NO:	Page 2 of 2	

RESPONSIBLE DEPARTMENTS

Support Services -- Risk Management
Auditor-Controller

REFERENCES

Administrative Update--07/13/2012
Board Policy Resolution No. 2001-10--8/14/01 (Amended)
Board Policy Resolution No. 95-4--3/14/95 (Amended)
Board Policy Resolution No. 92-4--8/18/92
Personnel Manual Section 1172 (repealed)
California Labor Code Section 4653

TEMPORARY TRANSITIONAL WORK ACCOMMODATION AGREEMENT

**EMPLOYEE KEEP
FOR REFERENCE**

After each medical appointment:

- Provide any work restrictions given by the physician to your Supervisor.
- Your work status will be determined and you will be advised to take one of the following sets of actions:

A. If you are released to Usual & Customary position (full duty):

- ^ Your Supervisor will advise you to return to work.

B. If you have any work restrictions:

- ^ Your Supervisor will engage you in an interactive process to determine if an appropriate Temporary Transitional Assignment is available. If an assignment is available, you will review and sign the *Temporary Transitional Work Accommodation Agreement*.

C. If you are Totally Temporarily Disabled:

- ^ If you are unable to return to any assignment, you maybe contacted regarding your work status.

D. If you are Permanently Disabled:

If you become permanently unable to return to the Usual & Customary position, the Personnel Department will initiate an interactive process with you to identify a Modified or Alternative placement within the County as available.

- Continue treatment with your Treating Physician and, after each appointment, provide Work Restrictions to your Supervisor. If at any time you wish to change treating physicians, you must notify Risk Management immediately.

Initial Distribution:
Employee:

Employee
Retain for reference

FMLA LEAVE NOTIFICATION

**EMPLOYEE KEEP
FOR REFERENCE**

TO: Employee

FROM: Risk Management

This memo has been included in the Claim Form Packet in case you become Totally Temporarily Disabled from Usual and Customary work as a result of an injury/illness that may be work-related.

If you do become Totally Temporarily Disabled from Usual and Customary work, and if you are eligible for leave under the Family & Medical Leave Act (FMLA), then all leaves of absence related to the injury/illness will be considered part of the 12-week period of job protection designated by the FMLA.

If you would like more information about the FMLA and/or your eligibility, please contact your Supervisor.

PROOF OF SERVICE BY MAIL

I, _____, declare I am, and was, at the time of this service over the age of 18 years. I served a **WORKERS' COMPENSATION EMPLOYEE CLAIM FORM PACKET**, on (date) _____ by depositing one copy of said document in the United States Post Office mailbox at Redding, Shasta County, California. The document was in a sealed envelope with postage fully prepaid and addressed to:

(STATE FULL NAME AND ADDRESS AS IT APPEARED ON THE ENVELOPE)

Name

Address

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

Name – Please Print

Signature

Date

Department

Business Address

OSHA FORM 301 EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in duplicate (Type if possible) NOI two copies to:		OSHA CASE NO.
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 enforcing workers compensation benefits or payments is guilty of a felony.				FATALITY <input type="checkbox"/>
California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee was previously injured or ill, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.				
1. FIRM NAME		9. Policy Number		Please do not use this column
2. MAILING ADDRESS (Number, Street, City, Zip)		10. Phone Number		
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)		11. Location Code		CASE NUMBER
4. NATURE OF BUSINESS; e.g., Painting outdoors, stockbroker, grocer, farmer, etc.		8. State unemployment insurance act no.		OWNERSHIP
5. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____				INDUSTRY
7. DATE OF INJURY OR ILLNESS OCCURRED (mm/dd/yy)		12. TIME INJURY/ILLNESS OCCURRED		OCCUPATION
11. DATE EMPLOYEE BEGAN WORK (mm/dd/yy)		16. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		
1. LIKELY TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. DATE LAST WORKED (mm/dd/yy)		SEX
13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>		
15. PREVIOUS DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No		AGE
17. DATE OF EMPLOYER'S KNOWLEDGE, NOTICE OF INJURY/ILLNESS (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)		
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED; MEDICAL CONDITIONS if available, e.g., Severe degree burn on right arm, laceration on left elbow, head poisoning				
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		21. COUNTY		DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED; e.g., Shipping department, machine shop.		23. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAYS PER WEEK
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED; e.g., Acetylene, welding torch, farm tractor, scaffold		25. Other Workers Injured or ill in this county? <input type="checkbox"/> Yes <input type="checkbox"/> No		WEEKLY HOURS
26. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED; e.g., Working rebar of metal forms, loading boxes onto truck.				
27. 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 wet material. As he fell, he landed against brick wall, and burned right hand. USE SEPARATE SHEET IF NECESSARY.				
28. Name and address of physician (mm/dd/yy) (if possible) MD		29. Phone Number		NATURE OF INJURY
30. Hospitalized under separate hospitalization? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, list hospital and address of hospital (number, street, city, zip))		31. Phone Number		PART OF BODY
32. Date of hospitalization (mm/dd/yy)		33. Date of discharge (mm/dd/yy)		SOURCE
ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See OCR Title 8 14300.23 (b)(8)-(10) & 94300.38(b)(2)(B)(2). Note: Detailed names, addresses and vital employee information as listed in OCR Title 8 14300.08(x)(2)(C)(3).				
34. EMPLOYEE'S NAME		35. SOCIAL SECURITY NUMBER		EVENT
36. HOME ADDRESS (Number, Street, City, Zip)		37. PHONE NUMBER		SECONDARY SOURCE
38. OCCUPATION (regular job title, NO ACRONYMS, abbreviations or numbers)		39. DATE OF BIRTH (mm/dd/yy)		
40. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours		41. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		EXTENT OF INJURY
42. GROSS WAGES/SALARY \$ _____ per _____		43. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Completed By (type or print)		Signature & Title		Date (mm/dd/yy)
* Confidential information may be disclosed only to the employee, former employee, or the personal representative [OCR Title 8 14300.26], to claim for the purpose of processing a workers' compensation or other insurance claim; to other certain enforcement agencies; to a public health or law enforcement agency; or to a consultant hired by the employer [OCR Title 8 14300.20]. OCR Title 8 14300.40 requires provisions upon request to certain state and federal workplace safety agencies.				
FORM 301 (06/07) June 2002		FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY		

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

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

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

(name of doctor)(M.D., D.O., or medical group)

(street address, city, state, ZIP)

(telephone number)

Employee Name (please print):

Employee's Address:

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation:

Signature: _____ Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

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

Title 8, California Code of Regulations, section 9783.

Predesignation of Personal Physician; Reporting Duties of the Primary Treating Physician
Regulations 8 C.C.R. section 9780, et seq. (Approved 02/12/2014)

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

(name of chiropractor or acupuncturist)

(street address, city, state, zip code)

(telephone number)

Employee Name (please print):

Employee's Address:

Employee's Signature _____ Date: _____

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

