CHAPTER 10

HOW TO FILE A WORKERS’ COMPENSATION CLAIM

AND

REPORTING ON-THE-JOB INJURIES AND ILLNESSES
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.)

Revised 12/18/15
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.
INSTRUCTIONS FOR COMPLETING DECLINATION OF MEDICAL TREATMENT (DMT)

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 form.

Supervisor and/or Department Workers’ Compensation Coordinator:

□ Review and complete the supervisor section of the Declination of Medical Treatment form.
□ In Addition, complete and sign the bottom portion of the Supervisor’s Incident Report.
□ Have each witness complete and sign a written witness statement, if applicable.
□ Send completed “original” Declination of Medical Treatment form, Supervisor’s Incident Report and witness statements to your department’s Workers’ Compensation Coordinator for review.
□ Retain a copy of the Declination of Medical Treatment form, Supervisor’s Incident 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.

Revised 3/17
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 Declination 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 Administrator, Director of the Division of Workers’ Compensation (California Labor Code Section 4801.1).

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: ________________________________

JOB TITLE: ________________________________

DATE REPORTED: ________________________________

INCIDENT REPORTED TO: ________________________________

DATE OF INCIDENT: ________________________________

LOCATION OF INCIDENT (building location, department, etc.): ________________________________

TIME OF INCIDENT: ________________________________

TIME BEGAN WORK: ________________________________

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.):

☐ 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:

☐ Application of antiseptics

☐ Application of bandage(s)

☐ Use of nonprescription medications

☐ Removal of foreign bodies not embedded in eye (only irrigation required)

☐ Removal of foreign bodies from wound (uncomplicated procedure, for example, using tweezers)

☐ Application of ointments to abrasions to prevent drying or cracking

WHO WITNESSED THE INCIDENT?

☐ The above information is true and correct to the best of my knowledge.

☐ 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)

☐ Employee declined medical treatment

☐ Employee received minor first aid on-site as noted above.

SUPERVISOR (Print Name): ________________________________

DEPARTMENT HEAD (OR DELEGATE): ________________________________

SIGNATURE: ________________________________

DATE: ________________________________

SIGNATURE: ________________________________

DATE: ________________________________

TELEPHONE: ________________________________

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

WCC: Risk Management

Revised 4/28/10
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 CalOSHA Area Office (800-963-9424) 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, 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 – Workers’ Compensation after signing it via email (contact WC at 225-5141 for direction regarding which email(s) to use), 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.

Revised 5/4/18
# SHASTA COUNTY RISK MANAGEMENT

## SUPERVISOR’S INCIDENT REPORT

### EMPLOYEE NAME: [Field]  
**Gender:** [Male] [Female]  
**Full Time:** [ ] [Part Time: ]  
**Department:** [Field]  
**Work Phone No.:** [Field]

### 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:** [Field]  
**Time of Incident:** [Field]  
**Location of Incident:** [Field] (building location, department, etc.).  
**Date Reported:** [Field]  
**Time Began Work:** [Field]

### DESCRIPTION OF INCIDENT

- [ ] Has a similar incident occurred in the past? Yes [ ] No [ ]
- [ ] Have you contacted Fleet [ ] Facilities [ ]

**Description of the Incident:** [Field] (Brief description of the incident).

**Description of the Injury:** [Field] (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, properly guarded, etc.

### HOW INJURY OCCURRED

- [ ] Investigate how the injury occurred, and determine whether it was caused by an unsafe act or 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
- [ ] Confined or Distracted Work
- [ ] Failure to Use Proper Personal Protective Equipment (PPE)
- [ ] No Unsafe Act

#### UNSAFE CONDITION (IF ANY)

- [ ] Inadequate Lighting
- [ ] Unprotected Equipment
- [ ] Trips/Slip Hazards on Floor
- [ ] Unsafe Arrangement of Items
- [ ] Improper Dress or Apparel

### PREVENTIVE ACTIONS TO BE TAKEN

- [ ] Provide Additional Training
- [ ] Disciple Employee
- [ ] Modify/Continuous Work Practice
- [ ] 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: [Field]  
Date claim form provided to employee: [Field]

Has employee returned to work? Yes [ ] No [ ]
Name of clinic, physician, or hospital: [Field]

Date employee returned to work: [Field]  
* Indicate if sick leave was used: Yes [ ] No [ ]

What type of 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):** [Field]  
**Title:** [Field]  
**Department Head (or Delegate):** [Field]

**Signature:** [Field]  
**Date:** [Field]

**Telephone:** [Field]

### 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:** [Field]  
**Signature:** [Field]  
**Date:** [Field]

Revised 8/28/15
EMPLOYEE INSTRUCTIONS FOR
COMPLETING DWC-1 FORM

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-1 Form. 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-1 Form 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-1 Form. When completing the DWC-1 Form, 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-1 Form, 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-1 Form 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-1 Form 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.

Revised 10/2016
WORKERS' COMPENSATION CLAIM FORM (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 have recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

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

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

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

Empleado: Complete la sección “Empleado” y entregue la forma a su empleador. Gblese con la copia designada “Recibo Temporal del Empleado” hasta que UST, reciba la copia firmada y fechada de su empleador. UST, puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para obtener información gratuita. Una explicación de los beneficios de compensación de trabajadores está incluida en la Notificación de Posible Calidad, que es la hoja de portada de esta forma. Guardar y guardar esta notificación como referencia para el futuro.

UST también deberá haber recibido de su empleador un folleto describiendo los beneficios de compensación del trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviar notificaciones electrónicamente, y usted acepta recibir estas notificaciones sólo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la casilla apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe informar a su empleador por escrito.

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

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

1. Name. Nombre. ________________ Today’s Date. Fecha Hoy. ________________


3. City. Ciudad. ____________________________ Time of Injury. Hora en que ocurrió __________ a.m. __________ p.m.

4. Date of Injury. Fecha de la lesión (accidente). ____________________________

5. Address and description of where injury happened. Dirección donde ocurrió el accidente. ________________

6. Describe injury and part of body affected. Describa la lesión y el parte del cuerpo afectado. ________________

7. Social Security Number. Número de Seguro Social del Empleado. ________________

8. Check if you agree to receive notices about your claim by email only. Marque si acepta recibir notificaciones por correo electrónico. ________________

9. __________ Please give your e-mail. Correo electrónico del empleado ________________

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. UST recibirá notificaciones de beneficios por correo ordinario si el correo electrónico. ________________

2. Signature of employee. Firma del empleado. ________________

Employee—complete this section and see note below. Empleado—complete esta sección y note la notación abajo.

10. Name of employer. Nombre del empleador. ________________

11. Address. Dirección. ________________

12. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. ________________

13. Date claim form was provided to employer. Fecha en que se le entregó el empleado la petición. ________________

14. Date employer received claim form. Fecha en que el empleador recibió la petición del empleado. ________________

15. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. ________________

16. Insurance Policy Number. Número de la póliza de seguro. ________________

17. Signature of employer representative. Firma del representante del empleador. ________________

18. Title. Título. ________________ 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. This form must be returned to your agent or insurer within five working days of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY.

EMPLOYER COPY/Copia del Empleado. EMPLOYEE COPY/Copia del Empleado. CLAIMS ADMINISTRATOR/Administrador de Reclamos. TEMPORARY RECEIPT/Recibo del Empleado. ________________

Rev. 1/1/2016

Signature/Firma ________________ Date/Fecha ________________
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-1 Form “Employee’s Claim for Workers’ Compensation Benefits.”**

Supervisor:

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

☐ Complete the **Supervisor’s Incident Report.**

Distribution of Forms:

☐ Employee: Keep the pink copy of **DWC-1.**

☐ Supervisor: Send original DWC-1 and Supervisor’s Incident Report to your Department Personnel Technician for completion of the OSHA 5020.

☐ Department Personnel Technician: forward all originals to Risk Management Immediately.

<table>
<thead>
<tr>
<th><strong>Employee:</strong> Sign here to acknowledge receipt of the Claim Form Packet</th>
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<tbody>
<tr>
<td>EMPLOYEE’S SIGNATURE</td>
</tr>
<tr>
<td>Check to indicate treatment location:</td>
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<tr>
<td>☐ Designated Medical Facility ☐ Pre-designated Physician</td>
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</table>

Revised 07/2010
**EMPLOYER'S REPORT OF OCCIDENTIAL INJURY OR ILLNESS**

**COMPLETION INSTRUCTIONS:** Please complete in duplicate (type if possible). Mail two copies to:

**OSHA CASE NO:**

**FATALITY:**

Any person who makes any false or fraudulent material statement or 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 five days of knowledge every occupational injury or illness which results in lost time beyond the day of the incident OR 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 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.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. Firm Name</td>
<td></td>
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<tr>
<td>2. Mailing Address</td>
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<td>3. Location</td>
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<tr>
<td>4. Nature of Business</td>
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<td>5. Type of Employer</td>
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<td>6. Date of Injury</td>
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<td>7. Time Injury Occurred</td>
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<td>8. Time Employee Began Work</td>
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<td>9. Reason Employee Died</td>
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<td>10. Date of Death</td>
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<td>11. Full Days Worked</td>
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<td>12. Date Last Worked</td>
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<td>13. Date Returned to Work</td>
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<td>14. If Still Off Work</td>
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<td>15. Date Employee Was Provided Claim Form</td>
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<td>16. Specific Injury/illness</td>
<td></td>
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<td>17. Occupation</td>
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<td>18. Industry</td>
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<td>19. Source of Injury</td>
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<td>20. Date of Birth</td>
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<td>21. Social Security Number</td>
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<td>22. Home Address</td>
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<td>23. Sex</td>
<td></td>
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<tr>
<td>24. Occupation</td>
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<td>25. Extent of Injury</td>
<td></td>
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<tr>
<td>26. Gross Wages/Salary</td>
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<td>27. Hospitalized as an Inpatient Overnight</td>
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<td>28. Other Workers Injured or Ill in the Event</td>
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<tr>
<td>29. Employee Treated in Emergency Room</td>
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<tr>
<td>30. Days Per Week</td>
<td></td>
</tr>
<tr>
<td>31. Weekly Hours</td>
<td></td>
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<tr>
<td>32. Weekly Wage</td>
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<td>33. Rating</td>
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<td>34. Number of Cases</td>
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<td>35. Date of Hire</td>
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<tr>
<td>36. Date of Death</td>
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</table>

**ATTENTION:** This form contains information relating to employer 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 et seq. & 14300.40 et seq.

**Note:** Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.05(b)(5). Use separate sheet if necessary.

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 claim or other insurance claim, and under certain circumstances to a public health or law enforcement agency or a consultant hired by the employer (CCR Title 8 14300.20). CCR Title 8 14300.49 requires provision upon request to certain state and federal workplace safety agencies.

**FORM 5025 (Rev.7) June 2002**

**FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY**
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:


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,

Steve Taylor
Workers’ Compensation Analyst III

Angelika King
Workers’ Compensation Adjuster II

Enclosures

11/20/2017
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.

Revised 08/2016
# AUTHORIZED PHARMACIES FOR ON THE JOB INJURY/ILLNESS PRESCRIPTIONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<td>1300 DANA DR</td>
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<td>CA</td>
<td>96003</td>
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<tr>
<td>COTTONWOOD DRUG</td>
<td>20635 GAS POINT RD</td>
<td>COTTONWOOD</td>
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<tr>
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<td>CA</td>
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<tr>
<td>CVS DRUG STORE</td>
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<td>OMNICARE REDDING</td>
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<tr>
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<tr>
<td>RITE-AID PHARMACY</td>
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<td>96002</td>
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<tr>
<td>RITE AID PHARMACY</td>
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<td>OWENS PHARMACY</td>
<td>9387 DESCHUTES RD 1</td>
<td>PALO CEDRO</td>
<td>CA</td>
<td>96073</td>
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</tbody>
</table>

11/17/2016
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

Revision 12/27/16
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 St., 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 _____________ (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 _________________________________
AUTHORIZATION TO RELEASE INFORMATION

PATIENT’S NAME: ________________________ SSN: ____________________

AKA: ______________________________

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 as a maiden name. Please list the above whether or not it is related to this injury.

<table>
<thead>
<tr>
<th>YOUR FAMILY DOCTOR:</th>
<th>ANY OTHER PHYSICIANS:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. ____________________</td>
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<td>_______________________</td>
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<td>_______________________</td>
</tr>
<tr>
<td>HOSPITALS AND CLINICS:</td>
<td>2. ____________________</td>
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<tr>
<td>1. ____________________</td>
<td>_______________________</td>
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<td>2. ____________________</td>
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<tr>
<td>3. ____________________</td>
<td>_______________________</td>
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<td></td>
<td>_______________________</td>
</tr>
</tbody>
</table>

CHIROPRACTORS:

| 1. ____________________ |
| _______________________|
| _______________________|
| _______________________|

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 __________________________ Claim Number __________________________

Revised 12/2017
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.
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
SHASTA COUNTY RISK MANAGEMENT
WORK ACCOMMODATION GUIDE

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 Transitional Assignment/Light Duty is available. If an assignment is available, you will review the *Work Accommodation Meeting* form.

C. **If you are Totally Temporarily Disabled:**

   If you are unable to return to any assignment, you may be contacted regarding your work status.

D. **If you are Permanently Disabled:**

   If you become permanently unable to return to the Usual & Customary position, the 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.**
SHASTA COUNTY RISK MANAGEMENT
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.

Revised 07/2010
<table>
<thead>
<tr>
<th>Activity</th>
<th>Never 0 Hours</th>
<th>Occasionally Up to 3 hrs</th>
<th>Frequently 3-6 hrs</th>
<th>Constantly 6-8 hrs +</th>
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<td>Walking</td>
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<td>Standing</td>
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<tr>
<td>Bending (neck)</td>
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<tr>
<td>Bending (waist)</td>
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<td>Squatting</td>
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<td>Climbing</td>
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<td>Crawling</td>
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<td>Twisting (waist)</td>
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<tr>
<td>Ability to drive a vehicle</td>
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<td>Ability to dress w/o assistance</td>
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<td>Hand use / dominant hand: Right or Left (please circle)</td>
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<tr>
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<td>Fine Manipulation</td>
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<tr>
<td>Pushing / Pulling</td>
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<tr>
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**LIFTING**

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<th>Frequently 3-6 hrs</th>
<th>Constantly 6-8+ hrs</th>
<th>Height</th>
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</tr>
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**CARRYING**

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<th>Distance</th>
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<tr>
<td>100+ lbs</td>
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Physician’s signature ___________________________ Date ___________________________

PLEASE RETURN BY FAX TO RISK MANAGEMENT (530) 225-5251
Medical Mileage Expense Form  
Forma De Gastos Por Distancia Recorrida Por Visitas Medica

If you have to travel to get treatment for your work injury, you are entitled to re-payment of your travel costs. The mileage rate is ** cents per mile. Mileage for reasonable travel to the pharmacy, parking, bridge tolls, public transportation and other travel-related costs are also included. Complete this form. Attach receipts. Send the original to Shasta County Risk Management, and keep a copy.

Si tiene que viajar para recibir tratamiento por una lesión en el trabajo, usted tiene derecho a recibir un reembolso de ** centavos por milla. Millas por un viaje de distancia razonable a la farmacia, estacionamiento, pago de peaje, transporte público y otros viajes y costos relacionados están también incluidos. Complete esta forma y adjunte los recibos. Envíe la forma original a la Shasta County Risk Management y guarde una copia.

<table>
<thead>
<tr>
<th>Date/ Fecha</th>
<th>Travel from (include address)</th>
<th>Travel to (include name and address of doctor, hospital, therapist etc.)</th>
<th>Round trip mileage/ Milla viaje Redondo</th>
<th>Parking Estacionamiento</th>
<th>Tolls/Peaje</th>
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</tbody>
</table>

California law requires the following to appear on this form:
Any person who knowingly presents a false or fraudulent claim for a payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Las Leyes de California establecen que la siguiente declaración aparecerá en este formulario. Cualquier persona que a sabiendas presente reclamos falsos o fraudulentos para el pago de una pérdida, será culpable de un delito y se le podría multar y encarcelar en la penitenciaria estatal.

<table>
<thead>
<tr>
<th>Total Miles</th>
<th>X .545 Miles =</th>
<th>$</th>
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</thead>
<tbody>
<tr>
<td>Total Parking</td>
<td>$</td>
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<tr>
<td>Total Tolls</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total Reimbursement Requested</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

Signature / Firma

Printed Name / Imprima su nombre

Date / Fecha

***Note: from 01/01/11 to 12/31/13, mileage paid at $ .565 per mile
from 01/01/14 to 12/31/14, mileage paid at $ .56
from 01/01/15 to 12/31/15, mileage paid at $ .575
from 01/01/16 onward, mileage paid at $ .54
from 01/01/17 onward, mileage paid at $ .535
from 01/01/18 onward, mileage paid at $ .545

Revised 12/15/2017