SUBJECT: INDUSTRIAL INJURY COMPENSATION AND RETURN TO WORK

PURPOSE:

To provide a policy for accepted Workers' Compensation claims that ensures employees who suffer work-related injuries are provided medical treatment, industrial injury leave, compensation, and return to work opportunities in compliance with State law.

POLICY:

It is the intent of the City to ensure that all employees who suffer on-the-job injuries or illnesses receive prompt medical attention and that they are afforded all rights and benefits available to them through the Workers' Compensation system. The City will make every effort to return injured employees to work if they are medically able to do so.

1. Responsibility:

It is the responsibility of City employees to promptly report any job-related injury or illness to their immediate supervisor or to the Workers' Compensation Division. Supervisory personnel are responsible for ensuring that injured or ill employees receive prompt medical attention by the City's State approved Medical Provider Network (MPN). Supervisors must immediately report any incident to the Workers' Compensation Division by completing the necessary State forms within 24 hours of notice of injury.

The employee's supervisor will place the injured employee on industrial accident leave or modified duty when the authorized treating physician indicates the period of disability or modified duty will extend beyond the day of the accident (see HR Policy VI-02, Modified Duty Program). Appointments for treatment and therapy will be scheduled at the discretion of management in consideration of City operations. Employees are responsible for their own transportation to and from medical appointments, however
mileage is reimbursed by the City. Employees must submit to their supervisor any physician’s medical status report as soon as it is received from the physician.

2. **Compensation:**

A benefitted non-sworn employee will receive the negotiated percentage of salary continuance and the level of temporary disability payments required by Labor Code 4650. Local sworn safety personnel will receive full compensation according to Labor Code 4850. Non-benefitted, non-sworn employees will receive the State mandated total temporary disability rate of compensation.

Employees will continue to receive regular pay if the treating physician has stated that he/she can return to modified duty, provided a modified duty position is available that meets the employees work restrictions and physical limitations in accordance with the City’s Modified Duty Program.

Salary Continuance or Total Temporary Disability payments will be discontinued if an employee refuses to participate in the Modified Duty Program or does not participate or cooperate with the medical treatment prescribed by the treating physician. Furthermore, any refusal to participate in the Modified Duty Program will result in the employee remaining off work subject to departmental approval for time off and where sick leave cannot be used under this circumstance per HR Policy VI-02. Salary Continuance will also be discontinued if the employee retires, voluntarily or involuntarily terminates employment, or is on industrial injury or illness leave for a period exceeding one year. Where applicable, as per Labor Code 139.5, temporary disability payments will be paid after one year of Salary Continuance has been paid.

3. **Return To Work:**

The Workers’ Compensation Division will notify the immediate supervisor if the employee is released to temporary modified duty by their treating physician. Temporary modified duty assignments are made in accordance with HR Policy VI-02. If necessary, the Worker’s Compensation Division will arrange for any necessary medical treatment and/or any request for a change of treating physician.

If the employee’s condition is determined to be permanent and stationary by the treating physician with no permanent work restrictions, they will return to their usual and customary job duties. If the employee is deemed permanent and stationary and cannot perform the usual and customary duties of his/her position and has been given a permanent work restriction, they would be invited to the Reasonable Accommodation Interactive Process under HR Policy VI-04.

**Attachments:**
1. Supervisor’s First Report of Incident
2. State of California Claim Form
3. Instructions for State of California Claim Form
### SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

**PLEASE PRINT - COMPLETE ALL ITEMS IF DYC - 1 FORM SUBMITTED TO WORKERS’ COMP - SUBMIT IMMEDIATELY
COMPLETE HIGHLIGHTED ITEMS TO DOCUMENT FIRST AID INCIDENT ONLY**

### Employee:
- Dept/Div
- Classification:
- Address
- City/Zip.
- Home Phone.
- Date of Incident
- Time of Incident
- Date of Hire
- Shift
- Day
- Evening
- Night
- Date Incident Reported
- Reported to Whom?
- Location of Incident
- Type of Incident
- Injury
- Property Damage
- Equipment Damage
- Vehicle Collision
- Near-Miss
- Date Incidents Reported
- Time AM PM
- Time AM PM
- Time reported to work
- Date
- Time

### Type of Injury (check)
- Reaction to foreign substance/object
- Contusion
- Fracture
- Puncture
- Burn
- Amputation
- Loss of Consciousness
- Sprain / Strain
- Chemical Exposure
- Laceration
- Other

### Incidents Cause (check)
- Fall from stairs / obstacle / elevation
- Defective equipment
- Horseplay
- Other

### Witnesses
1. Name ___________________________ Dept/Address: __________ Phone: __________
2. Name ___________________________ Dept/Address: __________ Phone: __________

### City Vehicle Information:
- Year/Make/Model
- Type Vehicle
- Asset#
- Headlights on
- Yes
- No
- Warning Lights on
- Yes
- No
- Turn signals used
- Yes
- No
- Horn used
- Yes
- No
- Driver Name: ___________________________
- Address: ___________________________
- City: __________
- Phone: __________
- Driver’s License #: ___________________________
- Vehicle Year/Make/Model: ___________________________
- Vehicle License #: ___________________________
- Insurance Company & Policy #: ___________________________

### Damages:
List all damage to property, equipment and/or vehicles

### Select Conditions Present at Time of Incident:
- Sunny / Rain
- Bright Sun / Glare / Night
- Cloudy / Fog / Dusk / Dawn
- Windy
- Hot or Cold
- Floors wet / uneven
- Ventilation
- Other
- Environment (Internal / External)
- Tire condition
- Lights inoperative
- Lubrication
- Corroded
- Belt condition
- Insulation failure
- Belt adjustment
- Improper adjustment
- Loose / missing hardware
- Guards defective / missing
- Incorrect tool
- Defective materials
- Incorrect materials
- Improper design / type
- Other
- Equipment / Materials
- Fatigue
- Insufficient training
- Improper work practice
- PPE not used
- Action of other(s)
- Other
- Personnel

**Form No 1210.041 (8/03)**
| SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP |
| ATTACH ADDITIONAL SHEETS OF PAPER AS NEEDED FOR NARRATIVES |

**Employee statement on how incident occurred:**

- [ ] check box if statement is attached

**Employee statement on how recurrence could be prevented:**

- [ ] check box if statement is attached

**Describe in detail what employee was doing at time of incident (what, how, why):**

- [ ] check box if statement is attached

**Describe what act / condition(s) contributed to the incident (i.e., improper use of equipment, wet floor, etc.):**

- [ ] check box if statement is attached

**Supervisors conclusions:**

- [ ] check box if statement is attached

**Supervisors recommendation(s) to prevent recurrence:**

- [ ] check box if statement is attached

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Employee's Signature: ___________________________  Date: ___________________________

Supervisor's Signature: ___________________________  Date: ___________________________

Superintendent/Manager Signature: ___________________________  Date: ___________________________

**Distribution:**

City Safety Officer (Original)

Department / Division (File copy)

Safety Officer will route copies as needed
Claim Form (DWC 1)

To be provided to the employee within 24 hours at the time Workers’ Compensation Benefits are being requested (ie-medical treatment, time off work)

Employee- Needs to fill out sections # 1-8 completely.

Employer/Supervisor- Needs to fill out sections #9-17 completely

(#11 – reflects the date the Supervisor is notified that medical treatment or other benefits are being requested by the employee)

(#14 -- is always legally uninsured)

(#15 – leave blank)

**INCOMPLETE FORMS WILL BE RETURNED TO THE DEPARTMENT.**

Distribution: Original- Workers’ Compensation, 2nd copy-Department Division copy
Last two copies- To Employee

Treatment Facilities:

**Community Industrial Clinic – 4444 Magnolia Ave. (Urgent care side) Riverside, CA (951)274-3498**

**Inland Empire Occup. Clinic – 3579 Arlington Ave. #300 Riverside, CA (951)341-9333**

**Parkview Industrial Clinic – 9041 Magnolia ave. #107 Riverside, CA (951)-353-1021**

**Riverside Industrial Clinic- 2002 Iowa Ave. #104 Riverside, CA (951)682-2222**


**Park Sierra Medical Clinic - 3660 Park Sierra Dr. #101 Riverside,CA (951)359-7762**

Please call Workers’ Compensation Staff to report referrals to clinics

IN CASE OF EMERGENCY, PLEASE REPORT TO THE NEAREST HOSPITAL EMERGENCY ROOM
<table>
<thead>
<tr>
<th>Employee—complete this section and see note above</th>
<th>Empleado—complete esta sección y note la notación arriba.</th>
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<tbody>
<tr>
<td>3. City. Ciudad.</td>
<td>4. Date of Injury. Fecha de la lesión (accidente)</td>
</tr>
<tr>
<td>5. Address and description of where injury</td>
<td>6. Describe injury and part of body affected.</td>
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<tr>
<td>happened. Dirección lugar donde ocurrió el</td>
<td></td>
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<td>accidente.</td>
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<td>del Empleado.</td>
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| Employer: You are required to date this form and   | Empleado: Se requiere que Ud. feche esta forma y   |
| provide copies to your insurer or claims           | que provenga copias a su compañía de seguros,      |
| administrator and to the employee, dependent       | administradora de reclamos, o dependiente/        |
| or representative who filed the claim within one    | representante de reclamos y al empleado que hayan |
| working day of receipt of the form from the        | presentado esta petición dentro del plazo de un   |
| employee.                                         | día hábil desde el momento de haber sido recibida |
| | | la forma del empleado.                        |

**SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY**

☐ Employee copy/Copia del Empleado ☐ employee copy, Copia del empleado ☐ Claims Administrator/Administrador de Reclamos ☐ Temporary Recency/Recibo del Empleado
If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. You should read all of the information below. Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

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

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 11/04, there is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 11/05, has a medical provider network. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

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

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

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

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

Atención Médica: Su administrador(a) de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurrieron en o después de 11/04, hay un limite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende (Primary Treating Physician PTP) es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al PTP que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o después de 11/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento aplicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

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

Pago por Incapacidad Temporal (Suelos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de
Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury, illness.

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

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer does not offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

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

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

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 32a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

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

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling (800) 736-7401. You may also go to the DWC web site at www.dir.ca.gov. 1 link to Workers' Compensation.

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

Ayuda al Trabajador: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador(a) de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarlo a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado, o otro trabajo, podría extenderse o no temporalmente, dependiendo de la índole de su lesión o enfermedad.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapacidad temporal terminan, y su empleador no ofrece un trabajo modificado o alternativo, es posible que Ud. reúna los requisitos para la rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que vivían en el hogar, que dependían económicamente del de la trabajadora(a) difunta.

Es ilegal que su empleador le castigue o despidga, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Código Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

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

Ud. puede obtener información gratuita, de un oficial de información y asistencia, de la División estatal de Compensación al Trabajador (Division of Workers' Compensation DWC), o puede escuchar información grabada, así como una lista de oficinas locales. Llamando al (800) 736-7401. Ud. también puede ir al sitio electrónico en el Internet de la DWC en www.dir.ca.gov. Enlázese a la sección de Compensación para Trabajadores.

Ud. puede consultar con una(s) abogado(a). La mayoría de los abogados ofrecen una consulta gratuita. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California (State Bar) al (415) 538-2120, o vaya a su sitio electrónico en el Internet en www.californiaspecialist.org.