Approved:

City of Riverside, California
Human Resources Policy and Procedure Manual

Human Resources Director

City Manager

City of Arts & Innovation

Number: VI-01 Effective Date: 11/12

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 DWC – 1 FORM SUBMITTED TO WORKERS' COMP – SUBMIT IMMEDIATELY
COMPLETE HIGHLIGHTED ITEMS TO DOCUMENT FIRST AID INCIDENT ONLY

SUPERVISOR SECTION

Employee: Dept/Div Classification:

Address City/Zip. Home Phone.

Birthdate / / Age: M F Date of Hire / / Shift Day Evening Night

Date of Incident / / Time of Incident AM PM Time reported to work Date / / Time AM PM

Date Incident Reported / / Reported to Whom?

Location of Incident

Type of Incident Injury Property Damage Equipment Damage Vehicle Collision Near-Miss

(1) Was employee given 1st Aid Yes No (2) Was treatment refused by employee Yes No

Notify Workers' Compensation for "YES" answers to Items #3, #4 & #5

(3) Was employee sent to: Emergency Room Yes No Name of Hospital _____

Preferred Clinic Yes No Name of Clinic _____

Pre-designated Physician Yes No Name of Physician _____

Other _____

(4) Was employee admitted to hospital Yes No (5) Fatality Yes No

Did employee wear protective equipment Yes No List equipment used _____

Part of Body

No Injury

Fill in Blank (be specific)

_____

Type of Injury (check)

Reaction to foreign substance/object Contusion Fracture
Puncture Burn Amputation
Loss of Consciousness Sprain / Strain Laceration
Chemical Exposure OPIM Exposure
Other _____

Incident Cause (check)

Fall from stairs / obstacle / elevation Act or procedure Injury from falling objects Back injury from lifting
Defective equipment Fall on floor / surface Improper use of equipment / instrument
Horseplay Repetitive Motion
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

Seatbelts Worn: Driver Yes No Passenger Yes No Police Report # _____ Reporting Agency _____

Other Vehicle Information (if applicable)

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:

Environment (Internal / External)

Sunny Rain
Bright sun / glare Night
Cloudy / fog Dusk / dawn
Windy Other _____
Hot or Cold

Equipment / Materials

Tire condition Lights inoperative Lubrication Corroded
Belt condition Insulation failure Belt adjustment Leaking hose / fitting
Improper adjustment Loose / missing hardware Guards defective / missing
Incorrect tool Defective materials Incorrect materials
Improper design / type Other _____

Facility

Layout of equipment Floors wet / uneven
Housekeeping Ventilation
Lighting Other _____

Personnel

Fatigue Insufficient training Improper work practice PPE not used
Action of other(s) Other _____

Form No 1210.041 (8/03)

SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

ATTACH ADDITIONAL SHEETS OF PAPER AS NEEDED FOR NARRATIVES

EMPLOYEE SECTION

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

SUPERVISOR SECTION

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: (Type of training, repair/replace equipment, etc) check box if statement is attached

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
*****US HealthWorks – 1760 Chicago Ave. Ste. J3 Riverside, CA***
(951)781-2200
*****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

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

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

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

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

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

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

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

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

7/1/04 Rev.

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

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

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

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

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 1/1/04, 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 1/1/05, 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 lesiona o se enferma, ya sea física 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 usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el/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 "Empleado", guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador", le dará a Ud. una copia fechada, guardará una copia, y enviará una al/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere 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 ocurren en o después de 1/1/04, hay un límite 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 depués de 1/1/05 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 applicables 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/la juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal. 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

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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 or illness.

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

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't 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 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

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

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation, 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**. 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**.

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

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el la 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 regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado, u otro trabajo, podría extenderse o no temporalmente, dependiendo de la índole de su lesión o enfermedad.

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

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para 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 Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

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

Es ilegal que su empleador le castigue o despida, 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 Codigo 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 al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División estatal de Compensación 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**. Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. 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, ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org**.