# CITY OF SAN BRUNO
## RETURN TO WORK PROGRAM

# EMPLOYEE MEDICAL TREATMENT PACKET

*(Updated June 2024)*

# CITY OF SAN BRUNO
# RETURN TO WORK PROGRAM
# EMPLOYEE PACKET

*(Rev. June 2024)*

**INSTRUCTIONS:** Complete this packet prior to medical treatment unless there is an emergency, in which case call 911.

❒ Employee: Read and sign the ***Receipt of Employee Packet form***.

❒ Employee: Read, complete and sign the top portion only of ***DWC Form 1***. Retain the cover sheet ("Notice of Potential Eligibility") and "Employee" copy for records. Supervisor: Complete bottom portion of ***DWC Form 1***.

❒ Employee: Complete and sign the ***Employee Injury Report***.

❒ Supervisor: Complete the ***5020 form***.

❒ Employee: Complete and sign the ***Authorization and Release of Medical & Employment Records and Information***.

❒ Supervisor: Complete the ***Supervisor's Incident/Accident Report*** (must be signed by both the Supervisor and Department Head).

❒ Supervisor: Complete the ***Treating Physician Letter*** (must attach employee's job description to this form).

❒ Supervisor: Complete the ***Treatment Authorization Form***.

❒ Employee: **Take the following forms to the Treating Physician:**

- ✓ **Treating Physician Letter**: *(completed by Department representative).*
- ✓ **Treatment Authorization Form (or SFO Medical Clinic Authorization Form *if employee receives treatment from SFO Medical Clinic)***: *(completed by Department representative).*
- ✓ **Patient Status Report**: *Physician to complete, sign, and return to City's return-to-work coordinator*

❒ Employee: **Read** the following forms for further instruction and information:

- ✓Directions to Medical Clinic
- ✓Work Status Guide
- ✓Overview of California Workers' Compensation System

**The Employee must return to the Department as directed with completed Patient Status Report immediately following medical visit, or if shift has ended, at the start of the next scheduled shift.**

❒ Supervisor: Original completed packet must be submitted to the Worker's Compensation coordinator asap.

# RECEIPT OF EMPLOYEE PACKET FORM

This packet has been given to the undersigned Employee in response to the injury that has been reported. By signing in the spaces below, the Employee and Supervisor (or Department Head) acknowledge that the Employee has received the Employee Packet for use throughout the course of this Workers' Compensation claim. The Employee Packet is a key component of the City of San Bruno Return to Work Program and must be completed in a timely manner.

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

*This notice has been approved by the Administrative Director of the Division of Workers' Compensation*

**We have reviewed the Employee Packet, and we have both completed and signed the necessary items.**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| *Employee's Signature* | *Print Name* | *Date* |
| _____ | _____ | _____ |
| *Supervisor's or Department Head's Signature* | *Print Name* | *Date* |

**Original: HR/Return to Work Coordinator**

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

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

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file 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 you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

**Medical Care:** Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

**The Primary Treating Physician (PTP)** is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

**Switching to a Different Doctor as Your PTP:**

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

**Atención Médica:** Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

**El Médico Primario que le Atiende *(Primary Treating Physician- PTP)*** es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

**Cambiando a otro Médico Primario o *PTP*:**

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

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

**Problems with Medical Care and Medical Reports**: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

**Payment for Temporary Disability (Lost Wages):** If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. 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.

**Stay at Work or Return to Work:** Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

**Payment for Permanent Disability:** If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

**Supplemental Job Displacement Benefit (SJDB):** If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

**Death Benefits:** If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

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

**Problemas con la Atención Médica y los Informes Médicos:** En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review- IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator- QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

**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. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

**Permanezca en el Trabajo o Regreso al Trabajo:** Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other 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.

**Resolving Problems or Disputes:** You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or 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) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

**You Can Contact an Information & Assistance (I&A) Officer:** State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

**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 website at **www.californiaspecialist.org**.

**Learn More About Workers' Compensation:** For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

**Pago por Incapacidad Permanente:** Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

**Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*:** Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

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

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

**Resolviendo problemas o disputas:** Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

**Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*:** Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

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

**Aprenda Más Sobre la Compensación de Trabajadores**: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

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 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.**

***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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

*Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al 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 enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de 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 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. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's 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. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

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

10. Name of employer. *Nombre del empleador.* City of San Bruno
11. Address. *Dirección.* 567 El Camino Real, San Bruno, CA 94066
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 employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
JT2 Integrated Resources, P.O. Box 8021, Pleasanton, CA 94588
16. Insurance Policy Number. *El número de la póliza de Seguro.* Self Insured
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* Return to Work Coordinator 19. Telephone. *Teléfono.* (650) 616-7057

**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*

**CITY OF SAN BRUNO**
**RETURN TO WORK PROGRAM**

# EMPLOYEE INJURY REPORT

| | |
|---|---|
| Employee: | Job Title: |
| Home Address: | Home Telephone: |
| Department: | Supervisor: |

| | | |
|---|---|---|
| Injury Date: | Time: | Location: |
| Date Reported: | Injury Reported to: | |
| Nature of Injury (e.g., strain, cut, fracture, dermatitis, multiple injuries, etc.): | | |
| Body Part Injured (e.g., Head, eye, leg, back, wrist, etc. Specify left/right, etc.): | | |
| Injury Source (e.g., supplies, equipment, desk, vehicle, person stairs, ladder, etc.): | | |
| How Injury Occurred (struck by …, fell from …, exposed to …, etc.): | | |

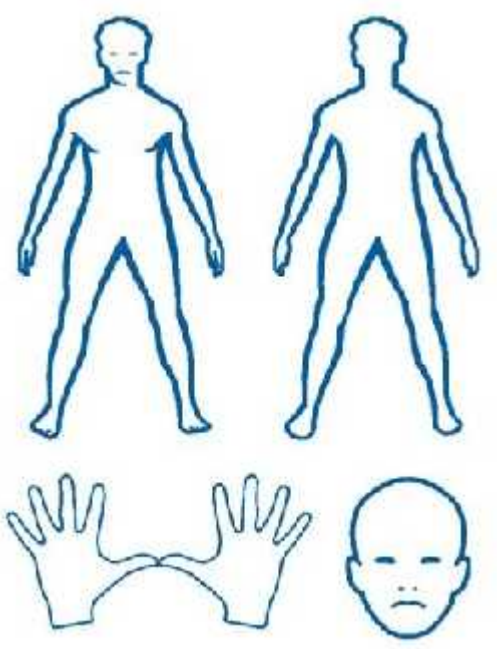
Employee's Statement of What Occurred. In your own words, please provide a detailed description of the incident: Include relevant events leading up to, during, and after the incident.

Who witnessed the incident?

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

Employee's Signature _____ Date _____

**Original: HR/Return to Work Coordinator**

| **Body Part – Please shade in the part(s) of the body that were/are injured** | **Injury Type -** Check all that apply |
|---|---|
|  | ☐ Ache/pain (gradual)<br>☐ Ache/pain (sudden)<br>☐ Amputation<br>☐ Broken Bone<br>☐ Bruising incl crushing<br>☐ Burns/scalds<br>☐ Chemical reaction<br>☐ Choking/suffocation<br>☐ Concussion/brain injury<br>☐ Cut (infected)<br>☐ Cut (not infected)<br>☐ Dental injury<br>☐ Dermatitis<br>☐ Dislocation<br>☐ Foreign Body (eye, ear, nose)<br>☐ Inhalation disease (asbestos/lead)<br>☐ Hearing Loss (noise induced)<br>☐ Poisoning<br>☐ Strain/Sprain<br>Other:_____ |

Was anyone else responsible for the injury? If yes, please list the parties and describe their involvement.

Did anyone witness the incident? _____ Yes _____ No
If yes, please list the name(s) of witness(es):

Have you done anything that may have caused or contributed to the injury? _____ Yes _____ No
If yes, please describe.

In your opinion, what can be done to prevent the incident from happening again?

Have you ever had a prior injury to the same part(s) of your body that was injured in this incident? (This includes both work-related injuries and non-work related injuries). _____ Yes _____ No

If yes, please describe in detail.

If the a prior work-related injury was disclosed above, please list the name of the employer(s) and the date(s) of the prior injuries.

# AUTHORIZATION AND RELEASE OF MEDICAL & EMPLOYMENT RECORDS AND INFORMATION

Today's Date: _____

| | |
|---|---|
| Employee Name: | |
| Address: | |
| | |
| Phone Number: | |

I, the undersigned, authorize any physician, chiropractor, psychiatrist/psychologist, nurse, physical therapist, or anyone else who has attended to me; or any hospital, medical clinic, mental health or substance abuse center at which I have been treated, or any insurance carrier, to furnish to JT² Integrated Resources, and/or its authorized representative, any and all medical information which may be requested regarding my physical or mental condition and treatment rendered thereof. I further authorize and request the release of any and all records of other health care providers that are in your files.

If necessary, this release permits JT² Integrated Resources, or its authorized representative, to examine and/or copy any x-ray pictures taken or records regarding my physical or mental condition and treatment contained in any file in possession of the person or entity to which this release is presented.

This release entitles JT² Integrated Resources, or its authorized representative, to contact my present and past employer(s), and to confirm my length of employment, wages, and any other employment data.

_____ _____

Employee's Signature Date

**Original: HR/Return to Work Coordinator**

# TREATING PHYSICIAN LETTER

To: **Treating Physician**

Re: Injured Employee: _____
(Print name of employee)

Our employee has been sent to your office for medical treatment of an injury that may be **work-related**.

The City of San Bruno has instituted a Return to Work Program and will attempt to modify the current position or place the employee into a Transitional Assignment during recovery. Please review the Employee's Usual & Customary Job Description and then use the enclosed Patient Status Report to outline the employee's current work capabilities. Note that **AB 435** which amends **Labor Code Section 3762 ©** does allow for the release of medical information to the employer in two instances:

1) If the diagnosis of the alleged Workers' Compensation injury would affect the employer's premium, or
2) If disclosure of medical information is necessary in order for the employer to modify the employee's work duties.

**The employee needs the completed Patient Status Report prior to leaving your office. The employee has been instructed to report to their Supervisor or Department Head immediately following the appointment.**

Should you have any questions or need to review additional information, please contact HR by telephone at (650) 616-7009.

Thank you for your full cooperation.

Sincerely,

HR Department
Return to Work Coordinator

Encl: Treatment Authorization Form
Patient Status Report
Employee's Usual & Customary Job Description

# TREATMENT AUTHORIZATION FORM

Today's Date: _____

| | |
|---|---|
| Employee Name: | |
| Date of Injury: | |
| Time of Injury: | |
| Employer: | City of San Bruno<br>567 El Camino Real, San Bruno, CA 94066-4299 |
| Authorized by: | *(Print Name)* |
| | *(Signature)* |

**After each doctor appointment, please fax a copy of the Patient Status Report to the Return to Work Coordinator at (650) 742-6515. The original copy of the Patient Status Report should be given to the injured Employee to return to their Supervisor or Department Head.**

Any invoices for **First Aid injuries** and billings related to **OSHA Recordable injuries** should be sent to our Workers' Compensation Third Party Administrator:

JT² Integrated Resources
P.O. Box 8021
Pleasanton, CA 94588
Phone: 800-582-4671 ext 5506
Fax: 209-491-7038

The City of San Bruno will provide modified or transitional work for most work restrictions. Please advise of any work restrictions for the injured Employee in all Patient Status Reports.

***Any appointments, including physical therapy, should be scheduled, if possible, after the completion of the employee's workday.***

Thank you.

# CITY OF SAN BRUNO

## SUPERVISOR'S INCIDENT/ACCIDENT INVESTIGATION REPORT

In order to prevent accidents, we must know how and why they occur. State facts as accurately as possible. Submit your report to the City Manager's Office within 24 hours. If more space is needed, attach additional sheets.

| Department or Division | Name of Immediate Supervisor Making Report | | Phone Number |
|---|---|---|---|
| | | | |
| **Location of Incident** | **Date of Occurrence** | **Time** | **Date Reported** |
| | | | |

**PERSONAL INJURY** **PROPERTY DAMAGE**

| Injured's Name | | Property Damage |
|---|---|---|
| | | |
| **Occupation** | **Injured Part of the Body** | **Estimated Costs** |
| | | |
| **Nature of Injury** | | **Nature of Damage (If None, Please State)** |
| | | |

**Describe in Detail, How the Incident Occurred**

**What Acts and/or Conditions Contributed Most Directly to this Incident?**

**In Detail What Action Has or Will be Taken to Prevent Recurrence**

**Please Check ALL That Apply**

- ☐ Inadequate Training
- ☐ Inadequate equipment/tools
- ☐ Inadequate protective gear
- ☐ Poor housecleaning
- ☐ Inadequate facility maintenance
- ☐ Inadequate equipment maintenance
- ☐ Employee physical limitations
- ☐ Poor planning, design, layout
- ☐ Inadequate procedure
- ☐ Failure to follow procedures
- ☐ Emergency / haste
- ☐ Hazard exposure / haste
- ☐ Environmental factors
- ☐ Act of another
- ☐ Vandalism
- ☐ Horseplay
- ☐ Inattention
- ☐ Insufficient information
- ☐ Unknown cause
- ☐ Assault
- ☐ Vegetation (poison oak / Ivy)

| | | |
|---|---|---|
| | | **Est. Date Condition Will Be Corrected** |
| | | **Has Employee Returned to Work** |
| **Signature of Immediate Supervisor** | **Date** | **Investigated Incident?** |
| | | |
| **Signature of Department Director** | **Date** | **Information Given Complete & Correct?** |
| | | |

Copies: _____ City Manager _____ Department ____ TPA ____ Employee

State of California

**EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

**Please complete in triplicate (type if possible) Mail two copies to:**

**OSHA CASE NO.**

**FATALITY** ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee 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.

## EMPLOYER

**1. FIRM NAME**
City of San Bruno

**1a. Policy Number**

**Please do not use this column**

**2. MAILING ADDRESS: (Number, Street, City, Zip)**
567 El Camino Real, San Bruno, CA 94066

**2a. Phone Number**
(650) 616-7057

**CASE NUMBER**

**3. LOCATION if different from Mailing Address (Number, Street, City and Zip)**

**3a. Location Code**

**OWNERSHIP**

**4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.**
Municipal Government

**5. State unemployment insurance acct.no**

**6. TYPE OF EMPLOYER:** ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

**INDUSTRY**

## INJURY OR ILLNESS

**7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)**

**8. TIME INJURY/ILLNESS OCCURRED**
_____ AM _____ PM

**9. TIME EMPLOYEE BEGAN WORK**
_____ AM _____ PM

**10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)**

**OCCUPATION**

**11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY?** ☐ Yes ☐ No

**12. DATE LAST WORKED (mm/dd/yy)**

**13. DATE RETURNED TO WORK (mm/dd/yy)**

**14. IF STILL OFF WORK, CHECK THIS BOX:** ☐

**SEX**

**15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED?** ☐ Yes ☐ No

**16. SALARY BEING CONTINUED?** ☐ Yes ☐ No

**17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)**

**18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)**

**AGE**

**19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning**

**20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)**

**20a. COUNTY**

**21. ON EMPLOYER'S PREMISES?** ☐ Yes ☐ No

**DAILY HOURS**

**22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.**

**23. Other Workers injured or ill in this event?** ☐ Yes ☐ No

**DAYS PER WEEK**

**24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold**

**WEEKLY HOURS**

**25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.**

**WEEKLY WAGE**

**26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY**

**COUNTY**

**27. Name and address of physician (number, street, city, zip)**

**27a. Phone Number**

**NATURE OF INJURY**

**28. Hospitalized as an inpatient overnight?** ☐ No ☐ Yes **If yes then, name and address of hospital (number, street, city, zip)**

**28a. Phone Number**

**29. Employee treated in emergency room?** ☐ Yes ☐ No

**PART OF BODY**

**ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.**

**Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.**

**SOURCE**

## EMPLOYEE

**30. EMPLOYEE NAME**

**31. SOCIAL SECURITY NUMBER**

**32. DATE OF BIRTH (mm/dd/yy)**

**EVENT**

**33. HOME ADDRESS (Number, Street, City,Zip)**

**33a. PHONE NUMBER**

**SECONDARY SOURCE**

**34. SEX** ☐ Male ☐ Female

**35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)**

**36. DATE OF HIRE (mm/dd/yy)**

**37. EMPLOYEE USUALLY WORKS**
_____ hours per day, _____ days per week, _____ total weekly hours

**37a. EMPLOYMENT STATUS**
☐ regular, full-time ☐ part-time
☐ temporary ☐ seasonal

**37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED**

**EXTENT OF INJURY**

**38. GROSS WAGES/SALARY**
$ _____ per _____

**39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)?** ☐ Yes ☑ No

**Completed By (type or print)**

**Signature & Title**

**Date (mm/dd/yy)**

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

# PATIENT STATUS REPORT

| | |
|---|---|
| Employee Name: | Appointment Date: |
| Date of Injury: | Follow up Appointment Date: |

## WORK STATUS

A. ❒ Usual & Customary (Full Duty) B. ❒ Restricted Duty C. ❒ Total Temporary Disability

## WORK RESTRICTIONS

| | Maximum hours Employee can perform each activity per day | | | | |
|---|---|---|---|---|---|
| | **0 hours** | **2 hours** | **4 hours** | **6 hours** | **No restriction** |
| Sitting | ❒ | ❒ | ❒ | ❒ | ❒ |
| Standing/Walking | ❒ | ❒ | ❒ | ❒ | ❒ |
| Squatting | ❒ | ❒ | ❒ | ❒ | ❒ |
| Kneeling/Crawling | ❒ | ❒ | ❒ | ❒ | ❒ |
| Climbing | ❒ | ❒ | ❒ | ❒ | ❒ |
| Bending | ❒ | ❒ | ❒ | ❒ | ❒ |
| Twisting | ❒ | ❒ | ❒ | ❒ | ❒ |
| **HAND USE:** | | | | | |
| Reaching: | ❒ | ❒ | ❒ | ❒ | ❒ |
| Repetitive Hand Use | ❒ | ❒ | ❒ | ❒ | ❒ |
| Keyboard/Mouse Use | ❒ | ❒ | ❒ | ❒ | ❒ |
| Handwriting | ❒ | ❒ | ❒ | ❒ | ❒ |
| Fine Manipulation | ❒ | ❒ | ❒ | ❒ | ❒ |
| Power Grasping: | ❒ | ❒ | ❒ | ❒ | ❒ |
| **LIFTING/ CARRYING:** | | | | | |
| 0-10 lbs. | ❒ | ❒ | ❒ | ❒ | ❒ |
| 11-25 lbs. | ❒ | ❒ | ❒ | ❒ | ❒ |
| 26-50 lbs. | ❒ | ❒ | ❒ | ❒ | ❒ |
| 51-75 lbs. | ❒ | ❒ | ❒ | ❒ | ❒ |
| 76 + lbs. | ❒ | ❒ | ❒ | ❒ | ❒ |

| | | |
|---|---|---|
| Can Employee operate a vehicle? | ❒ Yes | ❒ No |
| Can Employee work around moving equipment? | ❒ Yes | ❒ No |

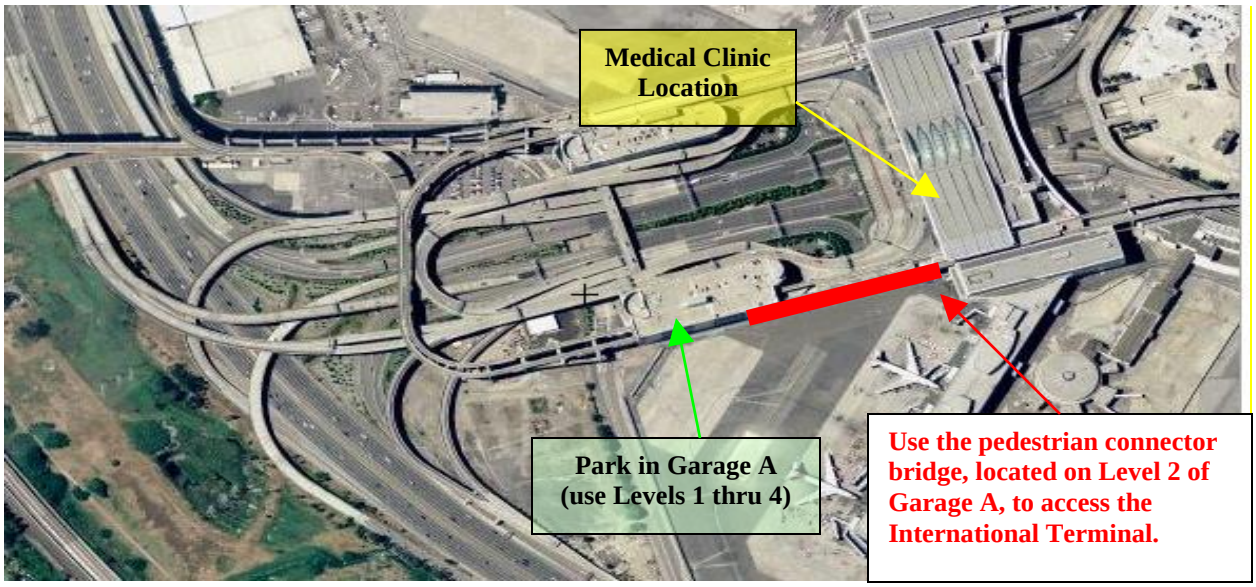
| |
|---|
| Physical Therapy: |

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Name: | Signature: | Date: |
| Telephone: | Fax: | Email: |

# DIRECTIONS TO MEDICAL CLINIC

## *SFO Medical Clinic*
## *San Francisco International Airport*
## *International Terminal, Level 3, A Side*




Exit Highway 101 to San Francisco International Airport and follow signs to International Terminal Departures – Hourly Parking. Stay in the right lane to enter International Parking Garage A. You enter on Level Five and will park on Levels One through Four. Use the pedestrian connector bridge, located on Level 2 of Garage A to access the International Terminal. When you enter the terminal, take the elevator to Level Three (departures). The Clinic is located to your right when you exit the elevator.

**SFO Medical Clinic**
San Francisco International Airport
International Terminal, Level 3, A Side
Hours:
Monday through Friday: 8:30 a.m. to 5 p.m.
Phone: 650-821-5601

**After-hours**
**Full-Service Emergency Care**
**(Seven days, 24 hours)**
Mills-Peninsula Medical Center
***(Peninsula Hospital)***
Emergency Department
1501 Trousdale Drive
Burlingame, CA 94010
(650) 696-5170



***Employee's Copy***

# WORK STATUS GUIDE

After each medical appointment, report back in person to your Department as instructed and return the Patient Status Report. The Supervisor or Department Head will determine your work status and take one of the following actions:

**A. <u>If you are released to Usual and Customary position (full duty):</u>**

- ❒ Return to work.
- ❒ Return to Treating Physician for any indicated follow up appointments until you are released from care. **Be sure to bring a Patient Status Report back to your Department as instructed after each appointment.**

**B. <u>If you have any work restrictions:</u>**

- ❒ The Supervisor or Department Head will determine if an appropriate Transitional Assignment is available. If so, read, complete and sign the Transitional Assignment Agreement.
- ❒ If a Transitional Assignment is not available, the Supervisor or Department Head will telephone on a weekly basis at a set time to your home, to "check-in" to see how recovery is progressing. Both parties will agree upon the time and day of the week.
- ❒ Continue treatment with Treating Physician. **Be sure to return a Patient Status Report to your Department as instructed after each appointment.**

**C. <u>If you are Totally Temporarily Disabled:</u>**

- ❒ If you are unable to return to any assignment, the Supervisor or Department Head will telephone on a weekly basis at a set time to your home, to "check-in" to see how recovery is progressing. Both parties will agree upon the time and day of the week.
- ❒ You will be receiving a letter from the Return to Work Coordinator regarding Total Temporary Disability Benefits if your leave of absence extends beyond the salary continuation period.
- ❒ Continue treatment with Treating Physician. **Be sure to return a Patient Status Report to your Department as instructed after each appointment.**



***Employee's Copy***

# OVERVIEW OF CALIFORNIA WORKERS' COMPENSATION SYSTEM

The California Workers' Compensation System is a "no fault" system. Barring gross negligence, an injured Employee cannot sue his or her employer. A Workers' Compensation claim is not a lawsuit and does not require an attorney. Any fees for services rendered by the injured Employee's attorney are deducted directly from the injured Employee's benefits received through the Workers' Compensation System. The Workers' Compensation System was established and is closely monitored and controlled by the State of California.

The City of San Bruno's Workers' Compensation Third Party Administrator is JT² Integrated Resources, which can be reached at (800) 582-4671 ext. 5506. If you have questions that cannot be answered by a City staff member or JT² Integrated Resources, you may contact an Information and Assistance Officer at the nearest office of the State Division of Workers' Compensation at (800) 736-7401. This information service is free.

The three parts of a Workers' Compensation claim are:

I. Medical Treatment
II. Compensation Payments for Lost Wages
III. Claim Resolution

The State of California has outlined each of these areas and Workers' Compensation Labor Code laws govern them each.

## I. Medical Treatment

The State of California requires the City of San Bruno to provide all reasonable and necessary medical treatment to the injured Employee. The injured Employee pays no deductible and no co-payments. All costs are paid directly by the City through JT² Integrated Resources for the treating physician, medicines, hospital charges, lab fees, therapy, equipment such as crutches, back braces, etc., as well as injured Employee's mileage for such appointments. The City chooses the treating physician for the first 30 days of treatment **IF** the employee has not previously designated a treating physician in writing. The City's designated medical clinic is ***SFO Medical Clinic***, located at ***San Francisco International Airport, International Terminal, Level 3***.

## II. Compensation Payments

The State of California requires that the City of San Bruno provide compensation to injured Employees who are unable to work for a period of time. If an Employee is unable to work for more than three days because of a work-related injury/illness, the City will provide the injured Employee with Total Temporary Disability payments (TTD) until the treating physician releases the injured Employee back to his or her Usual and Customary occupation, or until the injured Employee enters a Transitional Assignment, or returns to work with a modification of the Usual and Customary job duties. Workers' Compensation will pay 2/3 of the injured Employee's Average Weekly Wage up to the California State maximum per week. Above and beyond this benefit, the City provides a 60-calendar-day salary continuation if you qualify. City Employees who are covered under California Labor Code Sections 4850-4856 are entitled to a leave of absence without loss of salary, in lieu of temporary disability payments or maintenance allowance payments, which would be payable for the period of the disability, but not exceeding one year. For questions regarding compensation, contact the Return to Work Coordinator at (650) 616-7057 or JT² Integrated Resources at (800) 582-4671 ext. 5506.



***Employee's Copy***

**III. Claim Resolution**

The State of California guarantees that when medical treatment has brought the injured Employee to the point of maximum medical improvement and the injury has resulted in permanent disability residuals (permanent restrictions given by the treating physician), the City is responsible for a "permanent disability" payment to the injured Employee. The amount will be determined based on the percentage of disability and in accordance with the established amounts provided by the California Labor Code laws in compliance with Workers' Compensation Code. When "permanent restrictions" are given concerning the injured Employee, the City may modify the Usual and Customary assignment or offer a new Alternate assignment within the City (RU-94). If Modified or Alternate work is not available, then the injured Employee will be offered supplemental job displacement benefits.

## COMMON TERMS USED FOR WORKERS' COMPENSATION

**DOI (Date of Injury):** The date a work-related injury occurs. For repetitive motion or cumulative trauma injuries, the Date of Injury is the last day of exposure to the cause of trauma (i.e. last day worked.)

**DWC Form 1 "Employee's Claim for Workers' Compensation Benefits":** Division of Workers' Compensation (DWC) claim form, which is furnished by the employer and completed by the Employee after an industrial injury.

**Employee (EE):** The injured Employee.

**Qualified Injured Worker (QIW):** As determined by the treating physician, an Employee whose injury permanently precludes the Employee from performing his/her Usual and Customary occupation, and the Employee can reasonably be expected to return to gainful employment through Modified/Alternate placement at the City (RU-94).

**Job Description:** Each Employee is provided with a copy of the Job Description for their position at the time of hire. At that time, the Employee reviews and signs the Job Description. This Job Description will be given to the Treating Physician for use during the Workers' Compensation claim.

**Treating Physician:** The doctor primarily responsible for managing, monitoring, and reporting about the medical care and treatment of the injured Employee. Also referred to as Treater or Tx.

**Usual and Customary Occupation:** The employee's regular job at the time of injury (not necessarily the activities performed while injury occurred).