**RIALTO UNIFIED SCHOOL DISTRICT**

**EMPLOYEE'S REPORT OF WORK INDUSTRIAL INJURY/ILLNESS**

**Report all Injuries within 24 hours**

**Injured worker required to complete this form and give to Supervisor**

**(Form must be completely filled out)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Employee: | | | | | | | | | | | | | |
| (First) | | | (MI) | (Last) | | | | | | | | | |
| Home Address (Number, Street, City, Zip Code): | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Employee Number: | | | Date of Birth: | | | | | | | | Phone# |  | |
|  | | | Month: | | Day: | | Year: | | | |  |  | |
| Sex: |  | Occupation: |  | | | | | | | | | | |
| Male |  | Department/Site Assigned Too: | | | | | | | | | | | |
| Female |  |  | | | | | | | | | | | |
| Date of Hire: | | |  | | | On Employer's Premises? | | | | | | | |
| Month: | | Day: | Year: | | | Yes: | |  |  | No: | |  |  |
| Where did Incident or exposure Occur? (Address, City, and County) | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Date of Incident: | | | Time of Incident: | | | | | Shift Start Time: | | | | | |

What were you doing when injury occurred? (Please be specific, Identify tools, equipment or material you were using.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nature of injury/Illness (Please be specific: Identify part(s), of body, e.g., right/left, lower/upper, and type of injury e.g., sprain or laceration.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been treated for a similar injury/illness?  Yes  No

If yes, give date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and address of treating physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) and address of any witness(es) to this incident:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you exposed to another individual's blood or other bodily fluids?  Yes  No

Was another person responsible?  Yes  No Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require or desire medical attention at this time?

Yes (if so, please obtain a medical referral by calling the Risk Management Office at 820-7700 ext. 2111)

No (If not, please sign here): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have received the “Information for Injured Employees” (please initial) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CALIFORNIA LABOR CODE § 5401.7 STATES: “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 WORKER’ COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.**

**I declare under penalty of perjury that the foregoing is true and correct.**

Employee's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This document is not a waiver of workers’ compensation benefits as stated by Labor Code 5405(a), where no benefits have been provided, the injured employee has a maximum period of one (1) year from the date of injury to obtain medical treatment and benefits.**

**THESE INSTRUCTIONS TO BE GIVEN TO EMPLOYEE**

**RIALTO UNIFIED SCHOOL DISTRICT**

**INSTRUCTIONS FOR FILING INDUSTRIAL INJURY CLAIM**

California's no-fault compensation was passed by the State Legislature more than 60 years ago to guarantee prompt, automatic benefits to employees who sustain on-the-job injuries or illnesses. A Claims Administrator oversees the program to ensure that all Workers' Compensation benefits are paid to injured employees in accordance with State Regulations. The District wants you to know that its greatest concern is to see that you receive the best possible medical care and attention available, so your recovery is rapid and complete and you can return to your job.

**HOW TO CLAIM BENEFITS**

1. Prompt reporting is the key. You must notify your supervisor **immediately**, explaining what, when, where, why and how your injury or illness happened. The Claims Administrator will determine benefits. District procedure states that you must report the incident within 24 hours of the occurrence.

2. You or your supervisor should telephone the Risk Management Office at (909) 820-7700, ext. 2111, to report the injury and receive direction as to where you should go for treatment. You may see your own physician only if you have pre-designated your personal physician with the District, and the physician has agreed to treat workers’ compensation. Otherwise, the District is participating in a Medical Provider Network (MPN). Therefore, you will be treated within the MPN network.

3. You must complete the DWC-1/SAF-6 provided by your supervisor. Your supervisor will complete the "Supervisor's Accident Investigation Report.” You cannot claim benefits until the completed forms are returned to your supervisor.

4. All original doctors’ off-work orders, notices etc., should be submitted to the Risk Management Office. Without an approved authorized doctor's off-work order absences related to the injury will be charged to sick leave.

**WHAT ARE THE BENEFITS?**

California's Workers' Compensation system provides injured employees five kinds of benefits: Medical Care, Payment for Lost Wages, Permanent Disability, Rehabilitation Services and Death Benefits for Dependents.

**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 cost directly - you should never receive a bill. For injuries occurring on or after 01/01/04 there is a limit on some medical services. If physical therapy is required, these appointments **must be scheduled before or after your regular working hours**. Part-time employees must schedule their return doctor visits and physical therapy during their non-working hours. The District and/or the Administering Agency will remain in close contact with your treating physician throughout your treatment, to ensure that you are receiving the appropriate care.

**The Primary Treating Physician** (PTP) – If medical treatment is needed, your employer will direct you to an MPN provider upon initial report of injury. All medical non-emergencies, which require ongoing treatment, in-depth medical testing or a rehabilitation program, must be authorized by your claims examiner and based upon medically evidenced based treatment guidelines (California Labor Code § 5307.27, and as set forth in title 8, California Code of Regulations, section 9792.20 et seq.). Access to subsequent care, including specialist services, shall be available. Your employer will direct you to an MPN provider upon initial report of injury. You have the right to be treated by a physician of your choice within the MPN after your initial visit. If you wish to change your MPN physician after your initial visit, you may do so by accessing the on-line provider directories or call the toll free number to locate an MPN provider: 866-700-2168.

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

**Disclosure of Medical Records** – After you make a claim for workers’ compensation benefits, your medical records will not have the same privacy that you would usual expect. If you don’t agree to voluntary 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 are unable to work while you are recovering from a work related injury or illness, you will receive temporary disability payments. These payments are subject to change depending on your doctor’s medical assessment. Temporary Disability payments are 2/3 of your average weekly wage, within minimums and maximums set by the State of California. Payments for lost wages are not made for the first 3 days following the injury (including weekends.) However, if you are hospitalized or off work for more than 14 days, payments will be made for the first 3 days. The Education Code states that all permanent bargaining unit and management employees are entitled to their full wages for up to 60 working days. You are only entitled to the salary continuance for an industrial injury if you submit an authorized doctor’s off-work statement or a doctor’s appointment slip. If you are entitled to salary continuance, temporary disability benefits will be included in your regular paycheck. Workers’ Compensation payments are tax-free and do not include Social Security deductions.

**Return to Work** - is provided for you to be able to return to work as soon as medically possible. Your doctor and you must communicate with your employer any work restrictions necessary while recovering from the injury or illness. This is a 60 working day modified or temporary duty program. It is not intended to be a permanent accommodation. The modified or other duty may be extended depending on the nature of your injury or illness.

**Payment for Permanent Disability** – You may receive additional payments due to a permanent disability. Your treating physician will determine if a permanent disability has occurred. The amount will depend on the type of injury, your age, occupation, and date of injury.

**Vocational Rehabilitation** (VR) - is a benefit for injuries that occurred prior to 2004. If, because of your work incurred injury, you are unable to return to your usual job duties, and your employer does not offer modified or alternate work you may qualify for vocational rehabilitation benefits. Your claims administrator will pay the costs, up to a maximum set by state law.

**Supplemental Job Displacement Benefit (SJDB)** – If your employer does not offer regular, modified, or alternate work within 60 days of the receipt of a permanent and stationary report finding permanent partial disability from the primary treating physician, AME, or QME, you may qualify for nontransferable voucher payable to a school for retraining and/or skill enhancement.

**Death Benefits** - In the event of a work related death, eligible dependents will be entitled to benefits as determined by the State of California.

**Other Benefits** - Employees who are or have been members of Social Security should contact the nearest office of the Social Security Administration for information regarding possible disability benefits. Employees who are members of the Public Employees Retirement System or the State Teachers’ Retirement System should contact their branch office for information regarding disability benefits provided under these programs.

**WHEN WOULD BENEFITS BE DENIED?**

The District will not be responsible for the payment of Workers’ Compensation benefits for any injury which results if you are acting out of the course and scope of your regular employment. This could include voluntary participation in off-duty activities, disregard for supervisors directions or District procedures, self-provoked injuries, or willful misrepresentation.

**IF THERE IS A PROBLEM**

Most claims are handled routinely. Workers’ Compensation benefits amounts are set by the Legislature. If you have questions regarding your Workers’ Compensation benefits, contact the Risk Management Office at (909) 820-7700, ext. 2111.