City of Lakeport Illness and Injury Prevention Program	Date Written: 1-31-12 Revision date: 6-7-23

CONTENTS

ATTACHMENTS

I certify the Illness and Injury Prevention Program for the City of Lakeport has been reviewed and revised as necessary.

K. M. I. — 6/7/2023

Kevin M. Ingram, Lakeport City Manager — Date Certified

1.0 PROGRAM REVIEW AND CERTIFICATION

The Injury and Illness Prevention Program (*IIPP)* at the City of Lakeport (LKPT) will be reviewed and revised as necessary to ensure the program is current. All revisions are documented on Attachment A – Program Review and Certification Log.

2.0 PURPOSE AND POLICY STATEMENT

2.1 PURPOSE: To establish a Cal-OSHA mandated Employee Injury and Illness Prevention Program, in accordance with the California Code of Regulations, Title 8, Section 3203.

2.2 POLICY: LKPT holds the safety of our employees, as well as that of the public we serve, as a high priority. The consideration of worker safety, and the safety of the general public, bears as high a priority as the decision to commit funds or complete a task and no function is so critical as to require a compromise of safety.

LKPT is committed to providing a place of employment free from health and safety hazards, promoting

safe working practices, and complying with all applicable federal, state and City safety requirements.

2.3 RELATIONSHIP TO OTHER DOCUMENTS: This IIPP establishes policy and procedure for the City of Lakeport. Where other documents are referenced within this IIPP, they shall be treated as though they were a part of this document.

The LKPT wastewater treatment plant is subject to Process Safety Management. Only employees authorized and trained shall work with chlorine and other acutely hazardous chemicals. Reference the City of Lakeport Wastewater Treatment Plant Process Safety Management manual for acutely hazardous materials training and handling procedures.

3.0 RESPONSIBILITIES

3.1 **City Manager**: The City Manager has the overall authority and responsibility for implementing the provisions of the Injury Illness Prevention Program for the City of Lakeport. Specific responsibilities include, but are not limited to:

- Ensuring that the program targets losses, exposures, and is in compliance with applicable government standards.
- Providing active leadership & participation in the safety program.
- Holding those in management or supervisory positions accountable for safety and loss control.
- Establishing and/or supporting a safety committee, if established.
- Ensuring adequate funding is made available for the successful implementation of this program.
- Ensuring the safety program is fully implemented
- Ensuring policy and procedures are current.

3.2 **Safety Officer:**

The Safety Officer serves as a safety liaison between management, supervisors and employees and is responsible for administering, designing, and maintaining the safety program. Their responsibilities include the following:

- Providing support regarding all safety related issues.
- Reviewing, revising, and/or developing safety policies and procedures in order to keep the safety program updated and in compliance with CalOSHA requirements.
- Developing, implementing, and maintaining an effective safety program to prevent accidents, injuries, and illnesses.
- Coordinating with those in management or supervisory positions in the activities required to meet the provisions of the safety program.
- Implementing a training schedule to track and document that safety training and other CalOSHA requirements are scheduled and provided.
- Monitoring and coordinating safety training and events for compliance with the projected training schedule.
- Managing safety record keeping requirements.
- Participating in accident/incident investigations as necessary.
- Monitoring the effectiveness of the program and making recommendations to reduce risks and eliminate or control unsafe conditions in the work place.
- Monitoring and tracking periodic safety inspections for compliance with safety program requirements.
- Ensuring that all new employees receive New Employee Safety Orientation.
- Implementing systems to encourage employee participation in the safety program.

3.3 **Managerial and Supervisory Positions** are responsible for:

- Helping to develop a cooperative safety attitude by being an example to employees.
- Encouraging employees to report unsafe conditions, practices, and near misses.
- Completing their part of the New Employee Safety Orientation program in a timely manner for employees under their direct supervision.
- When appropriate, discussing safety concerns and safe job procedures as part of section meetings

- Ensuring documented tailgate meetings are occurring as required.
- Coordinating with the Safety Officer (or designee) to schedule, develop, implement, and document all workgroup safety training.
- Reporting & documenting all injuries, property damages, near misses, unsafe conditions and unsafe practices in accordance with this policy.
- Ensuring unsafe conditions or practices are evaluated and corrected in a timely manner
- Ensuring safety inspections are conducted and documented in accordance with this policy
- Conduct special safety inspections if new substances, job tasks, or equipment introduce new hazards to their employees
- Conducting accident\incident investigations when required by this policy, or as requested
- Ensuring employees receive prompt medical attention for all injuries/illnesses
- Ensuring that employees under their direct supervision know, understand and follow established safety guidelines
- Providing the necessary personal protective equipment to employees under their direct supervision and train them on its use

3.4 **Employees:**

It is the responsibility of each employee to follow safe working practices and comply with safety rules and regulations.

3.4.1 Specific responsibilities include, but are not limited to:

- Actively contributing to the success of the overall safety program
- Accomplishing their duties using safe work practices
- Reporting unsafe conditions and practices in accordance with Section 6.0 Hazard Assessment
- Conducting safety inspections of their respective work areas and/or equipment when requested
- Correcting any observed unsafe conditions or practices, when and where appropriate
- Immediately reporting all imminent and/or serious safety conditions/practices to their supervisor Maintaining good housekeeping duties pertaining to their work assignments
- Reporting all injuries to a supervisor as soon as possible
- Protecting themselves from hazardous exposures/conditions by using the proper engineering controls, administrative controls, and /or personal protective equipment when required or necessary
- Maintaining safety equipment in good condition with all safety guards in place when in operation
- Advising management when there is a need for job specific training
- Coaching fellow employees on safe work practices, whenever appropriate
- Participating on the Safety Committee when requested
- Taking the initiative to temporary suspend any work activity or unsafe conditions that they believe is an imminent or serious hazard (I.e. is immediately dangerous to life and health)

3.4.2 Employee rights include, but are not limited to:

- A safe and healthful working environment.
- Receive information and training in general safety and job specific work practices
- Refuse work that would violate a health and safety standard or order where such violation would pose a real and apparent hazard to his/her safety and health
- To not perform a job until they have received instructions and training on the proper and safe work procedures
- Contact CalOSHA about unsafe or unhealthful working conditions. Such complaints are strictly confidential per CalOSHA policy
- Have an employee representative accompany CalOSHA on an inspection and to talk privately to the CalOSHA representative during an inspection

4.0 COMPLIANCE

4.1 All employees, including managers and supervisors, are responsible for complying with safe and healthful work practices. LKPT's system of ensuring that all employees comply with these practices includes one or more of the following practices:

- Informing workers of the provisions of our Injury Illness Prevention Program.
- Evaluating the safety performance of all workers.
- Recognizing employees who perform safe and healthful work practices.
- Providing training to workers whose safety performance is deficient.
- Disciplining workers for failure to comply with safe and healthful work practices in accordance with the City's disciplinary procedures.

5.0 COMMUNICATION

LKPT recognizes that open, two-way communication between management and employees on health and safety issues is essential to an injury-free, productive workplace. The following systems of communication at LKPT are designed to facilitate a continuous flow of safety and health information between management and employees in a form that is readily understandable.

5.1 NEW EMPLOYEE ORIENTATION: Safety Orientations will be conducted at the time of hire and include a discussion of safety and health policies relevant to their position and stresses the importance of safety in the workplace. Safety orientation is a combined effort of the Safety Officer (or designee) and Supervisors and is documented using the New Hire Checklist or equivalent form anytime a new employee is hired.

5.2 REQUIRED SAFETY TRAINING: Employees will receive job specific training in accordance with the tasks they are required to perform, the hazards posed and regulatory requirements. This training will be provided either at time of hire as part of the New Employee Orientation, prior to performing the activity or being exposed to the hazard. All safety training will be documented on Attachment B: Safety Meeting & Training Attendance Form, or equivalent.

5.3 EQUIPMENT SAFETY TRAINING: Equipment safety training will be provided on all new equipment where training is necessary to prevent employee, coworker or third-party injury or property damage. This training will be documented on Attachment B: Safety Meeting & Training Attendance Form, or equivalent.

5.4 SAFETY POSTINGS: All appropriate and required safety information will be posted on the Lunch Room Bulletin Boards or in other locations that are highly visible and accessible to all employees.

5.5 REPORTING OF UNSAFE CONDITIONS OR PRACTICES:

5.6.1 Attachment C: Report of Unsafe Condition or Practice is used by employees to report any unsafe conditions, practices, or near misses they may have observed or experienced. Completed forms are given to the employee's immediate supervisor. Employees may submit completed forms anonymously, if they so choose. The Safety Committee will review all reports of unsafe conditions and determine the necessary actions needed to correct hazardous conditions in accordance with Section 8.0 Hazard Correction.

5.6 SPECIAL SAFETY MEETINGS: As appropriate, supervisors or managers will hold special safety meetings to review and discuss safety issues arising out of any unusual working conditions such new job activities, new equipment, on-site contractor activities, or other non-routine working conditions.

5.7 TAILGATE SAFETY MEETINGS: If job activities involve construction activities (i.e. alterations, painting, repairing, construction, maintenance, renovation, removal, or wrecking of any fixed structure or its part) tailgate meetings will be held every 10 days as required by the CalOSHA Construction Standard. Topics will be relevant to the job activity and associated job hazards. Other tailgate meetings are held as needed, or whenever a new job activity, work procedure, hazardous

substance or any other unusual working condition exists. All Tailgate Safety Meetings will be documented on Attachment B: Safety Meeting & Training Attendance Form, or equivalent.

5.8 LABOR/MANAGEMENT SAFETY COMMITTEE: LKPT utilizes a labor/management safety committee (*Committee)* that meets regularly but not less than quarterly. Minutes of Safety Committee meetings are posted on lunchroom bulletin boards. The Committee performs the following activities:

- Prepares written records of the safety and health committees meetings.
- Reviews results of the periodic scheduled inspections.
- Reviews investigations of incidents and exposures and makes suggestions to management for the prevention of future incidents.
- Reviews reports of unsafe conditions and determines if corrective actions are necessary.
- Submits recommendations to assist in the evaluation of employee safety suggestions.

5.9 EMPLOYEE ACCESS TO THE IIPP:

The term “access” means the right and opportunity to examine and receive a copy of the Injury and Illness Prevention Program.

- LKPT provides access to the Program to employees by providing unobstructed access to the Program document via the City’s document server plus a copy is available on the City’s website www.cityoflakeport.com.

6.0 HAZARD ASSESSMENT

Hazard assessment and correction activities include the following programs:

6.1 PERIODIC INSPECTIONS: LKPT will conduct documented safety inspections of the worksite and job activities in accordance with the following schedule in order to identify, evaluate, and correct workplace hazards and unsafe work practices.

- When the IIPP is first established.
- Inspections will be performed periodically. Periodic inspection frequencies are determined by a department’s work activities and associated hazards.
- When new substances, processes, procedures or equipment that present potential new hazards are introduced into our workplace.
- When new, previously unidentified hazards are recognized.
- When occupational injuries and illnesses occur.
- When employees are hired and/or reassigned to a process or work task for which a hazard evaluation has not been previously conducted.
- Whenever workplace conditions warrant an inspection.

6.2 SAFETY INSPECTION DOCUMENTATION AND TRACKING: All safety inspections and safety hazards discovered will be documented using Attachment D: Safety Inspection Report. The Safety Committee will review all completed inspection reports. Hazards and unsafe conditions will be prioritized for correction by the Safety Committee, or designee, according to the Section 8.0 Hazard Correction. The Safety Officer, or designee, will monitor the status of these hazards and unsafe conditions until they have been corrected. When hazards have been corrected, the date will be logged onto the corresponding Attachment D: Safety Inspection Report.

6.3 SPECIAL SAFETY INSPECTIONS: Special safety inspections will also be performed whenever:

- New substances, processes, or equipment are introduced to the workplace that represents a new occupational safety and health hazard.
- LKPT is made aware of a new or previously unrecognized hazard.

7.0 INCIDENT AND EXPOSURE INVESTIGATION

Employees are to report all work related injuries and illnesses to their immediate supervisor in accordance with Section 7.1. A thorough investigation will be performed depending upon the seriousness of the incident and/or injury as outlined in Section 7.2.

7.1 OCCUPATIONAL INJURY AND ILLNESS REPORTING PROCEDURES:

7.1.1 First Aid Injury: If the injury or illness is a minor first aid injury, the employee will report the injury or illness to their supervisor. The supervisor will log this information on the Supervisor's Log for Non-Treated Injuries (Attachment G) according to the Accident, Incident and Near Miss Investigation Procedures (Attachment F). Examples of minor first aid injuries include (but are not limited to) minor cuts, abrasions, or other injuries that only require flushing, cleansing, applying ointments, or require a covering such as a bandage, Band-Aid, or gauze pad. The purpose of recording these types of injuries is to ensure that all minor injuries & illnesses are dated in the event the injury/illness requires medical attention and/or becomes recordable (i.e. on the CalOSHA 300 Log) at a later date.

7.1.2 Recordable Injury: If the injury is beyond first aid (e.g. requires outside medical attention) the employee and their supervisor will follow the LKPT's Workers' Compensation claims procedures (Attachment H).

7.2 INVESTIGATION: LKPT will perform internal investigations of accidents, incidents and near misses in accordance with ATTACHMENT F: Accident, Incident and Near Miss Investigation Procedure. The main objective in conducting an investigation is to identify the root cause(s) of the accident or incident and make any changes necessary to prevent the accident or incident from occurring again.

7.2.1 **Purpose of the Investigation:** The main objective in conducting an investigation is to identify the root cause and any other factors that contributed to the incident so that steps can be taken to prevent the incident from occurring again.

7.2.2 **When to Investigate**: All occupational incidents will be evaluated and documented using the Employee Incident Report (Form DWC-01) and the Supervisor's Incident Report. Additionally, the following incidents will require a full investigation.

- Fatalities
- Serious Injury (i.e. inpatient hospitalization for a period of 24 hours for other than medical observation)
- Lost Time Injury
- Vehicle or equipment incident involving employee or third party injuries
- Vehicle or equipment incident involving third party property damages

7.2.3 **Procedure and Documentation**: An internal investigation of incidents will be performed using the Incident Investigation Report Form *(*Attachment E)

7.2.4 An incident evaluation and/or investigation will be performed as soon as possible after the supervisor has become aware that an incident has occurred

7.3 REPORTING TO CAL OSHA (in accordance with Title 8, Sections 330(h) and 342)

7.3.1 LKPT 's IIPP Administrator, or designee, will immediately make a telephone report to the nearest District office of the Division of Occupational Safety and Health of any serious occupational injury or illness, or death.

- **Immediately** means as soon as practically possible but not longer than 8 hours after LKPT knows or with diligent inquiry would have known of the death or serious injury or illness.
- **Serious injury or illness** means any injury or illness occurring in a place of employment or in connection with any employment which requires inpatient hospitalization for a

period of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.

7.3.2 The following information must be given in the report, if available:

- Time and date of accident.
- Employer's name, address and telephone number.
- Name and job title, or badge number of person reporting the accident.
- Address of site of accident or event.
- Name of person to contact at site of accident.
- Name and address of injured employee(s).
- Nature of injury.
- Location to where injured employee was moved.
- List and identity of other law enforcement agencies present at the site of accident.
- Description of accident and whether the accident scene instrumentality has been altered.

8.0 HAZARD CORRECTION

Whenever possible, workplace hazards and unsafe work practices will be corrected as soon as they are identified. If not corrected the day of discovery, a target date for correction will be established based upon the following criteria:

8.1 IMMINENT HAZARD: Imminent hazards are those conditions or practices that pose an immediate threat to the life or health of employees, public, or others who may be exposed. If not corrected, this activity or condition will likely cause a serious injury, serious illness, or fatality. If an imminent hazard is present, employees should stop activity and take immediate corrective action. If employees are unable or unsure what action to take, they will notify their supervisor who will take immediate corrective action, if possible. In either case, the employee shall document these condition(s) using Attachment C: Report of Unsafe Condition or Practice. If it is necessary for employees to enter the area to correct the hazardous condition, they will be provided with the necessary protection and will be trained to perform these duties. If the imminent hazard cannot be corrected, the hazard area shall be declared "off-limits" until the hazard is corrected.

8.2 SERIOUS HAZARD: Serious hazards are hazards that indicate substantial probability that an employee, public, or others will suffer physical harm. If a serious hazard is present, employees should stop activity and notify their supervisor. Serious hazards shall be corrected as soon as possible or shall be declared off limits until the hazard is corrected. The employee shall document these condition(s) using Attachment C: Report of Unsafe Condition or Practice.

8.3 GENERAL HAZARD: General hazards are those that may affect the safety and health of employees. General Hazards are brought to the attention of the supervisor using Attachment C: Report of Unsafe Condition or Practice. General Hazards will be corrected as appropriate.

8.4 REGULATORY HAZARD: A regulatory hazard pertains to permits, posting, record keeping, reporting requirements, or procedure deficiencies not directly affecting the safety and health of the employees. These deficiencies are noted on Attachment C: Report of Unsafe Condition or Practice for further review by the employee's supervisor and is corrected as appropriate.

9.0 TRAINING AND INSTRUCTION

All employees, including managers and supervisors, shall have training and instruction on general and job-specific safety and health practices. Training and instruction shall be provided as follows and documented using Attachment B: Safety Meeting/Training Attendance Record, or equivalent.

- When the IIP Program is first established.
- To all new employees.
- To all employees given new job assignments for which training has not previously provided.
- Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard.
- Whenever the employer is made aware of a new or previously unrecognized hazard.
- To supervisors to familiarize them with the safety and health hazards to which workers under their immediate direction and control may be exposed.
- To all employees with respect to hazards specific to each employee's job assignment.

10.0 RECORD KEEPING

The following safety records will be kept on file with LKPT for a minimum of 3 years.

- Incident investigations
- Safety Inspections
- Safety training records including the date of the training, the name of the person conducting the training, and a description of training contents
- Safety meetings including the names of attendees, the date and any safety items discussed
- Unsafe Condition or Practice Reports and corrective actions taken

ATTACHMENT A
Program Review and Certification Log

Injury and Illness Program Review and Certification Log		
Date	**Identify the IIPP Sections/Attachments Revised**	**Initial**
3/28/16	Added Section 2.3 (Relationship to other documents) to IIPP and specifically noted that WWTP operations are subject to Process Safety Management regulations.	A Britton
1/17/17	Updated Attachment D: Safety Inspection Report. Updated form includes entries for which department/division is being inspected and the name of the person completing the inspection.	A Britton
1/17/17	Updated Exhibit B: State of California form DWC 1 (Workers' Compensation Claim form). State using new form as of 1/1/16. Also added Title to form: Employee's Incident Report per the IIPP.	A Britton
1/17/17	Updated Exhibit C: added title to form: Supervisor's Incident Report per the IIPP	A Britton
10/26/17	Updated Attachment E: Incident Investigation Report Form. Updated to include elements of IIPP Exhibit C (Supervisor's Incident Report Form). Exhibit C eliminated from IIPP.	A Britton
10/26/17	Revised Attachment E, Page 2 to add area to record the Safety Committee's determination after it reviews an incident investigation report.	A Britton
1/30/19	Replaced Medical Service Order form (Page 26) with new form from Athens Administrators	A Britton
1/30/19	Updated Attachment D: Safety Inspection Report. Updated form includes additional entries for the department/division that is being inspected.	A Britton
4/1/2020	Updated Exhibit B: State of California form DWC 1 (Workers' Compensation Claim form) to include current insurance carrier info: Athens Administrators Updated Exhibit E: State of CA form 5020 / Employer's Injury Report form to include current insurance carrier info	A Britton
6/22/2022	Replaced Attachment H with updated City of Lakeport Workers' Compensation Claims Procedures. Also updated Attachment E, Page 1 to improve the Incident Investigation Report Form.	A Britton
6/29/2022	Added Witness Statement form to Attachment E. Minor change – cover page with CM's signature was not updated on the PDF distributed to staff.	A Britton
6/6/2023	Added Section 5.9: Employee Access to the IIPP as required by CCR Title 8, Section 3203 a. (8) Revised IIPP to be uploaded to City website – in the Public Works Document Center: https://www.cityoflakeport.com/public_works/documents.php#outer-1786 Reviewed & approved by City Manager.	A Britton
6/6/2023	Section 5.1: removed reference to My Safety Officer as City no longer uses their services. Reviewed & approved by City Manager.	A Britton

ATTACHMENT B

Safety Meeting/Training Attendance Record

TRAINING TOPIC: _____ DATE: _____

TRAINING LOCATION: _____

TRAINER: Print: _____ Sign: _____

TRAINING SUMMARY (*attach training handouts, fliers, etc)*: _____

NAME (please print)	SIGNATURE	DEPT.
1.		
2.		
3.		
4.		
5.		
6.		
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10.		
11.		
12.		
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14.		
15.		
16.		
17.		
18.		
19.		
20.		

ATTACHMENT C
Report of Unsafe Condition or Practice

Describe below the unsafe working condition, work practice, activity or equipment that you feel may result in injury or illness, workflow interruption or property damage. Forward the completed report to the Safety Committee. Please keep a copy for your records.

_____ CHECK HERE IF YOU BELIEVE IMMEDIATE ACTION IS REQUIRED.

Name of Person Submitting This Report: (Optional)	**Date:**
Location of Concern:	**Building/Room:**
Description of Unsafe Condition or Practice (If an injury, illness or work-flow interruption has resulted from this, please include details.):	
Diagram of Situation (if applicable):	
Suggested Remedial Action:	
Received by Safety Committee: (init)	**Date:**
Reviewed by Safety Committee: (init)	**Date:**
Referred to:	**Date:**
Remedial Action Taken:	
File completed reports in the Safety Files	

ATTACHMENT D

CITY OF LAKEPORT
225 PARK STREET, LAKEPORT, CA 95453 (707) 263-3578
compliance@cityoflakeport.com

Safety Inspection Report

Inspection Date: **Inspected By:**

City Department/Division: ☐City Hall ☐Police Department ☐Public Works/Corporation Yard ☐Public Works/Garage ☐Public Works/Administration ☐ Public Works/Water Division ☐ Public Works/Wastewater Division ☐ Public Works/Parks Division

Inspection Type: ☐Monthly ☐Quarterly ☐Annual ☐Special ☐New Equipment/Process

Hazard	Work Area:	Hazard Classification:	Corrected? (yes or no)	By: (Initials)	Date Corrected:

Hazard Classification Key:

I = Imminent Imminent hazards are those conditions or practices that pose an immediate threat to the life or health of employees, public, or others who may be exposed. If not corrected, this activity or condition will likely cause a serious injury, serious illness, or fatality. If an imminent hazard is present, employees should stop work activity and take immediate corrective action. If employees are unable or unsure what action to take, they will notify their supervisor who will take immediate corrective action, if possible. If the imminent hazard cannot be corrected, the hazard area shall be declared "off-limits" until the hazard is corrected.

S = Serious Serious hazards are hazards that indicate substantial probability that an employee, member of the public or other will suffer physical harm. If a serious hazard is present, employee should stop work activity and notify their supervisor. Serious hazards shall be corrected as soon as possible, or the hazard area shall be declared "off-limits" until the hazard is corrected.

G = General General hazards are those that may affect the safety and health of employees.

R = Regulatory Regulatory hazards pertain to permits, posting, record keeping, reporting requirements, or procedure deficiencies not directly affecting the safety and health of employees.

Post Inspection Procedures:

This Safety Inspection Report has been reviewed by:

Printed Name:

_____ (signature) _____ (date) _____

See Reverse Side for Safety Inspection Objectives & Area for Comments!

Send completed report to the Compliance Officer after all hazards have been corrected/addressed.

Form SC 1 Revised December 2018

ATTACHMENT E
Incident Investigation Report Form

To be completed by the affected employee's immediate Supervisor

Print Name: _____ Date: _____

Signature: _____

Title: _____

Purpose: The City of Lakeport evaluates and documents all occupational injury and illness incidents using this incident investigation form and the Employee Incident Report (Form DWC-01). Supervisors shall use this form to report all reported work-related injuries, illnesses, or first aid events (which could have caused an injury or illness) – no matter how minor. All incidents resulting in staff injuries, third-party injuries, property damages or fatalities caused by staff actions or City of Lakeport vehicles or equipment shall be investigated. This form is intended to help identify the root cause and any contributing factors so that a preventive action plan can be developed and implemented to prevent re-occurring incidents.

Step 1: Incident Information

Department	Date of Accident		Time a.m. / p.m.
Name of Injured	Age	Male ❑ Female ❑	Job Title
Nature of Injury			
Where did the incident occur? (Location address, department, street, building, public place, etc.)			
Who gave First Aid, if any?	Witness Names _____ _____		
Name/Address of physician	_____ **(See Pg 4, Witness Statement form)**		
Date injured worker given Employee Incident Report form (DWC-01)			

Step 2: Describe the Incident and Gather Additional Information:

A. Take photographs if appropriate and attach to this report
B. Get witness statements if appropriate and attach to this report
C. Attach a copy of the Employee's Incident Report form (DWC-01) to this report

Describe fully how the incident happened: What was employee doing prior to the incident? What equipment, tools being using? (Describe in detail & add separate page if needed.)

ATTACHMENT E

Incident Investigation Report Form (page 2)

Step 3: Identify Contributing Factors:

A. Identify what you consider to be contributing factor(s) to this incident. Use the list on Page 3 of this attachment for possible contributing factors.

Step 4: Summarize the root cause that contributed most significantly to this incident.

_____

_____

Step 5: Corrective Actions:

A. Taken:

_____

_____

_____

B. Planned:

_____

_____

_____

Step 6: Routing: Route completed incident review and investigation package to the appropriate department head for processing.

	Initial
Supervisor:	_____
Department Head:	_____
Safety Officer:	_____
Committee Review Date:	____/____/_____

Committee Recommendation: Preventable ❑ Non-Preventable ❑
Comments:

Step 7: Processing

The **Safety Officer** will process the incident investigation per Attachment F: "**Accident, Incident, Near Miss Investigation Procedures Flow Chart"**
Attachments to this report: 1. Employee's Incident Report - Form DWC-01 (required) 2. Photos (optional) 3. Witness Statements (optional)

ATTACHMENT E

Incident Investigation Report Form (Page 3)

Identifying Contributing Factors

Circle or mark any contributing factors:

A. Equipment & Tools Considerations:

1. Was the employee using the required safety equipment and using it properly?
2. Was the employee using the correct tools and using them properly?
3. Did the equipment and tools function as designed?
4. Was employee operating equipment without authority?
5. Did employee fail to secure equipment?
6. Were all guards in place?
7. Did employee ignore equipment defects or bypass safety controls?
8. Was equipment or tools unsafe to use due to poor maintenance and improper care?
9. Did Incorrect equipment labeling or identification contribute?

B. Personal Protection Equipment Considerations:

1. Was the employee wearing the appropriate level of PPE?
2. Was PPE inadequate (i.e. a higher level needed than required)
3. Did the PPE malfunction?
4. Was PPE damaged and/or poorly maintained?

C. Procedural Considerations:

1. Is there a written procedure for performing this job?
2. Was the procedure being followed?
3. Is the procedure insufficient (not technically correct or impractical to implement)?
4. Is there an inconsistency between the written procedure and actual practices?
5. Did the employee have adequate hands-on experience performing this procedure?

D. Training Considerations:

1. Was the employee trained on this task or procedure?
2. Should this activity or procedure require training (or additional training) for employees who perform it?
3. Was the employee performing this task according to the training they received?
4. Is additional training needed for this employee on this job task?

E. Did Employee's Physical Conditions Contribute?

1. Emotional stress
2. Fatigue
3. Medication or a medical condition
4. The task exceeded the employee's physical capabilities
5. Physical limitation (e.g. hearing, sight)

F. Did Environmental Considerations Contribute?

1. Temperature (cold or heat) or hazardous weather conditions
2. Slippery or wet conditions
3. The work area/task had a design issue
4. Defective raw materials
5. Poor lighting or ventilation
6. Noise or poor communications
7. Congestion
8. Hot surfaces
9. Poor storage practices
10. Soil conditions

G. Other Considerations:

1. Failure to warn co-workers
2. Risk taking behaviors (e.g. driving at high speeds)
3. In a hurry/ deadline pressures
4. Distracted/inattention
5. Suspected substance use or abuse
6. Horseplay
7. Peer pressure
8. Lack of pre-job briefing or inspection
9. Lack of supervision
10. Inadequate management of this task
11. Previously identified hazard was not abated or interim safety measures not implemented

Other:

_____
_____
_____
_____
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_____
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_____
_____
_____

ATTACHMENT E

Incident Investigation Report Form (Page 4)

WITNESS STATEMENT OF WORKERS' COMPENSATION OCCURRENCE

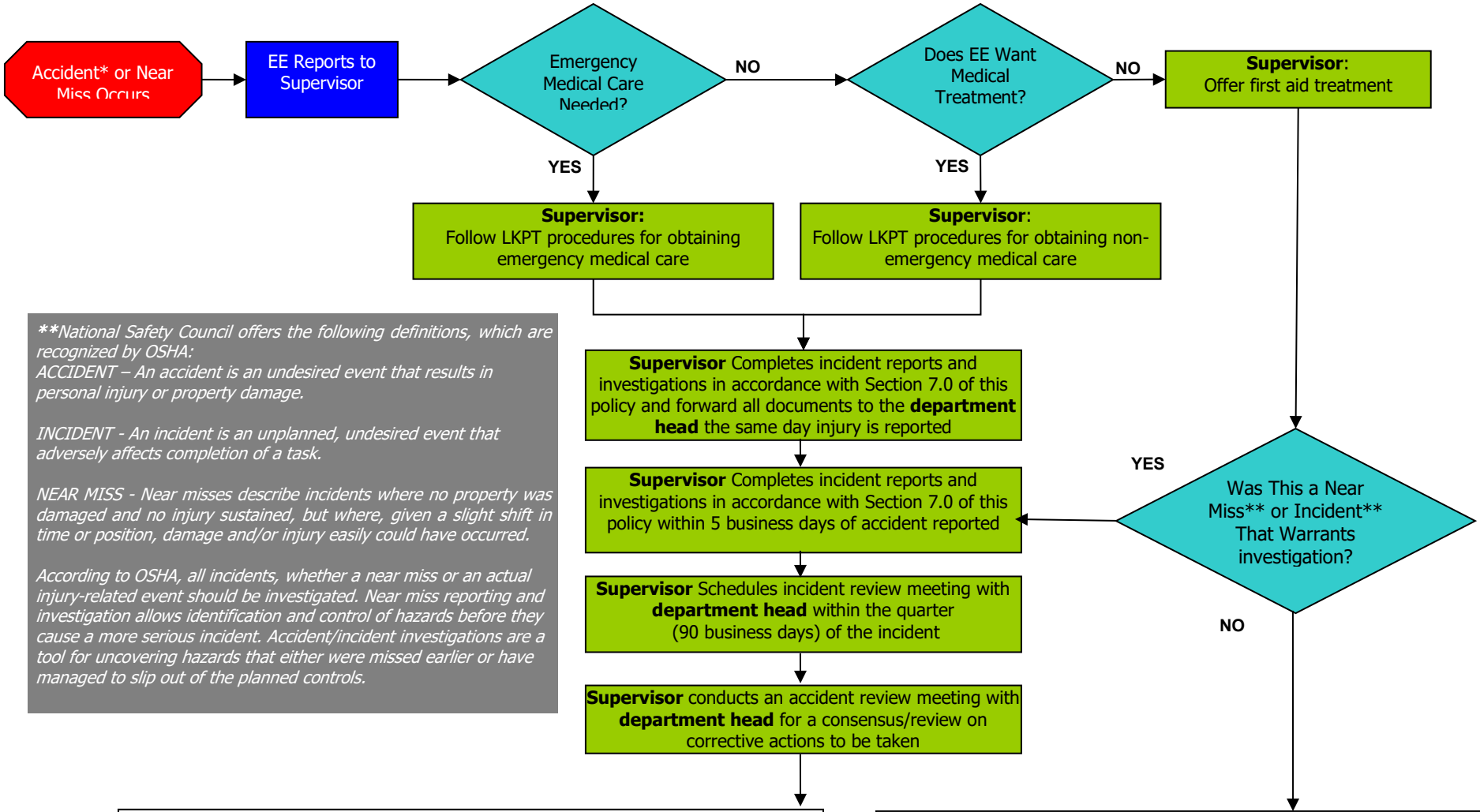
Instructions: Supervisors to provide this form to any person(s) who is (are) a witness to a work-related injury, illnesses events (which could have caused an injury or illness) – no matter how minor. This form shall be completed by the "witness" in their own words as observed of the work-related injury, illness or "incident".

Type of work-related incident reported: ☐ Injury ☐ Illness			
Date of incident:	Time of incident:	Other Employees involved in incident: ☐ Yes ☐ No	
Injured Employee Name:			
Witness Name:		Occupation:	Department:
Witness Telephone No.:			
Describe fully how the incident happened? What was employee doing prior to the incident? What equipment, tools being using? (Describe in detail)			
Were there witnesses? If so, list:			

I, the undersigned, hereby declare under penalty of perjury hat the above is true and correct to the best of my knowledge.

Witness name _____ Date _____

ATTACHMENT F:
Accident, Incident and Near Miss Investigation Procedure



***National Safety Council offers the following definitions, which are recognized by OSHA:*
ACCIDENT – An accident is an undesired event that results in personal injury or property damage.

INCIDENT - An incident is an unplanned, undesired event that adversely affects completion of a task.

NEAR MISS - Near misses describe incidents where no property was damaged and no injury sustained, but where, given a slight shift in time or position, damage and/or injury easily could have occurred.

According to OSHA, all incidents, whether a near miss or an actual injury-related event should be investigated. Near miss reporting and investigation allows identification and control of hazards before they cause a more serious incident. Accident/incident investigations are a tool for uncovering hazards that either were missed earlier or have managed to slip out of the planned controls.

ATTACHMENT G:
Supervisor's Log for Non-Treated Injuries (first aid log)

CITY OF LAKEPORT
SUPERVISOR'S LOG
(For Non-Treated Injuries)

DATE	TIME	EMPLOYEE NAME	NATURE OF INJURY	FIRST AID? DESCRIBE	NEAR MISS OR INCIDENT INVESTIGATION? Y/N WHY?	SUPERVISOR NAME
12/12/11	9:05 AM	Doe, Jane	Paper cut	Band Aid	No. Minor injury, no violations of policy.	
12/13/11	10:45 AM	Doe, Jane	Small Cut	Band Aid	Yes . Running with Scissors, possible violation of safety policy.	

ATTACHMENT H:
City of Lakeport Workers' Compensation Claims Procedure

CITY OF LAKEPORT
ADMINISTRATIVE POLICY

Subject: **WORKER'S COMPENSATION CLAIMS PROCEDURE**

Effective Date: **June 20, 2022**

I. PURPOSE

The purpose of this administrative procedure is to provide a uniform method of reporting and monitoring industrial (work-related) injuries. This procedure applies to all work-related injuries to City of Lakeport employees and in accordance with the city Illness and Injury Prevention Program (IIPP).

II. POLICY

It is the City's policy that all injuries requiring treatment (beyond first aid) shall be reported immediately to the injured employee's supervisor and documented according to the following procedures.

III. PROCEDURES:

A. Employee Designated Physician

Employees may pre-designate their own personal physician for treatment of work-related injuries. Designation of a personal physician shall be made on a form available in Human Resources (Exhibit A) at least 30 days in advance of the injury or incident. In the absence of the completed form, injured employees shall be treated at the City's designated medical treatment facility.

B. Injury Reporting

The following distribution of responsibilities is designed to expedite medical treatment and benefits provided by the City in accordance with Worker's Compensation law.

1. Employees:

a. Notify immediate supervisor of the work-related injury or illness.

b. If able, receive and sign the proof of service form. (Exhibit B.1)

c. Report promptly to the medical facility or designated personal physician for treatment using the Medical Treatment Authorization provided. (Exhibit B.5)

d. Request medical provider to complete the Physical Capacity Form (Exhibit B.6)

e. Use Optum First RX Fill to fill the first prescription, if any. (Exhibit B.7)

f. Complete the employee section of the Workers' Compensation Claim Form DWC-1. (Exhibit B.2)

g. Cooperate with supervisor in completing an Accident, Incident and Near Miss Investigation as delineated in the city's Illness and Injury Prevention Program (IIPP). (Exhibit B.9)

h. Return promptly from the medical facility or designated personal physician and submit the work status report to your supervisor.

i. Attend follow up medical exams.

j. Inform Department Head or Human Resources, if supervisor is unavailable.

2. **Supervisors:**

a. Refer to the Injury or Illness Reporting Packet on file in your department or found on the Department Drive at: S:\Administration\Human Resources

b. Provide the injured employee with:

- Proof of Service Form (Exhibit B.1)
- Worker's Compensation Claim Form DWC-1 (Exhibit B.2)
- DWC-1 Instructions & Notice of Potential Eligibility (Exhibit B.3)
- Notification Re. Medical Provider Network (Exhibit B.4)
- Employer's Medical Treatment Authorization (Exhibit B.5)
- Physical Capacity Form (Exhibit B.6)
- Optum First RX, first fill card (Exhibit B.7)
- Form 5020 Employer's Report of Injury (Exhibit B.8)
- Incident Investigation Report Form (Exhibit B.9)

c. If employee is able, get Proof of Service Form completed and signed.

d. Obtain a Medical Treatment Authorization form (Exhibit B.5) and an Optum First RX card (Exhibit B.7) from Human Resources or designee and coordinate transportation for the injured employee to the appropriate medical treatment facility.

e. Complete the Employers Report of Occupational Injury or Illness (Form 5020) and submit to Human Resources within 24 hours. (Exhibit B.8)

f. Complete an Investigation of Employee Injury using the Accident, Incident and Near Miss Investigation procedure in the city's Illness and Injury Prevention Program (IIPP) and submit the investigation documents to Human Resources or the Safety Officer within 24 hours. (Exhibit B.9)

g. Complete the employer section of the Workers' Compensation Claim Form (DWC 1) and submit to Human Resources. (Exhibit B.2)

h. Submit the physician's completed work status reports to Human Resources within 24 hours.

i. Review the physician's work status report to determine if alternative work may be available based on the physician's restrictions.

j. Submit all reports to the City's third-party administrator, LWP Claims Solutions, if Human Resources is unavailable.

3. **Human Resources**

a. Act as liaison between injured workers. medical treatment facilities, and LWP Claims Solutions.

b. Submit all required reports to LWP Claims Solutions.

c. Inform department management of the medical status of injured workers.

d. Assist in the evaluation of alternative work assignments as outlined in Section E of this procedure.

A. Timecards and Worker's Comp Payments

Timecards shall be noted when sick, vacation or other paid leave is related to a Worker's Compensation claim. If the leave qualifies as paid time-loss; the leave will be credited back to the employee leave bank except as follows:

The employee will not be paid time-loss for the first three (3) calendar days of missed work, unless the employee cannot return to work for 14 calendar days or unless the employee is admitted to the hospital in the first three days, in which case the employee will receive time-loss benefits for the first three days.

The employee will not be paid time-loss for follow up medical exams, referral exams or physical therapy visits.

B. Return to Work

Before an employee can return to work, the employee must present a written release from his/her treating physician indicating the employee may return to full duty without any restrictions. The release shall be presented to Human Resources before the employee returns to work.

In the case of the employees whose return to work would be delayed by presentation of the release to Human Resources, the management person in charge is authorized to accept the doctor's release if there are no restrictions noted on the release. The release is to be forwarded to Human Resources by the start of the next regular workday.

C. Return to Alternative Work

For an employee whose disability does not allow return to full, unrestricted duties, the City will endeavor to provide alternative work (light duty) if such work is available and within the employee's restrictions. Human Resources will schedule an interactive process meeting to determine light duty can be accommodated.

The employee shall return the completed physician's work status report to Human Resources. The report shall indicate the restrictions, if any, on the employee's work duties. Human Resources will confer with the employee's supervisor as to the alternative work assignments and make a determination whether an alternative work assignment is in the employee's and the city's best interests.

An employee may be accepted for an alternative work assignment if all of the following conditions exist:

- The employee has not suffered a permanent disability which will preclude return to the employee's usual job;
- The medical report indicates that the employee can perform the duties of the alternative work assignment without aggravating the current illness or injury;
- Work that the employee can perform is available, preferably in a classification and/or skill category related to the employee's regular classification or skill category, which is available, if directly related work is not available.

In the event that an alternative work assignment is unavailable, the employee shall be entitled to worker's compensation benefits as provided by the City and State Law.

III. RESPONSIBILITY

Human Resources shall provide any additions deletions or modifications to this Administrative Procedure.

Department Heads/Managers shall ascertain compliance with this procedure and inform their employees of the provisions set forth herein.

Employees shall promptly report work-related injuries; attend medical appointments; and submit work status reports from medical providers.

City Manager: Dated:

_____ _____
Kevin M. Ingram

EXHIBITS:

EXHIBIT A Predesignation Form 9783
EXHIBIT B CITY OF LAKEPORT INJURY OR ILLNESS REPORTING PACKET
- B.1 Proof of Service Form (Employee)
- B.2 Worker's Compensation Claim Form DWC-1
- B.3 DWC-1 Instructions & Notice of Potential Eligibility
- B.4 Notification Re. Medical Provider Network
- B.5 Employer's Medical Treatment Authorization
- B.6 Physical Capacity Form
- B.7 Optum First RX, first fill card
- B.8 Form 5020 Employer's Report of Injury
- B.9 Incident Investigation Report Form

EXHIBIT A
WC CLAIMS PROCEDURE

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

_____
(name of doctor) (M.D., D.O., or medical group)

_____ (street address, city, state, ZIP)

_____(telephone number)

Employee Name (please print):

_____

Employee's Address:

_____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee's Signature _____Date: _____

Physician: I agree to this Predesignation:

Signature: _____Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.

DWC FORM 9783 (7/2014)

EXHIBIT B
WC CLAIMS PROCEDURE

City of Lakeport Injury or Illness Reporting Packet

- ☐ Proof of Service Form *(Employee)* *B.1*
- ☐ Worker's Compensation Claim Form DWC-1 *(Employee & Supervisor)* *B.2*
- ☐ DWC-1 Instructions & Notice of Potential Eligibility *(Employee)* *B.3*
- ☐ Notification Re. Medical Provider Network *(Employee)* *B.4*
- ☐ Employer's Medical Treatment Authorization *(Provider)* *B.5*
- ☐ Physical Capacity Form *(Provider)* *B.6*
- ☐ Optum First RX, first fill card *(Provider)* *B.7*
- ☐ Form 5020 Employer's Report of Injury *(Supervisor & HR)* *B.8*
- ☐ Incident Investigation Report Form *(Supervisor)* *B.9*

B.1

WORKERS' COMPENSATION DOCUMENTS

Receipt – Proof of Service

MPN ID #2376 – LWP Claims Solutions Platinum MPN

I acknowledge that I have received the following workers' compensation documents:

- Workers' Compensation Claim form – DWC-1 & Notice of Potential Eligibility
- Medical Provider Network (MPN) notice

DOCUMENTOS DE COMPENSACION AL TRABAJADOR

Formulario de Reclamo de Compensación para Trabajadores

MPN ID #2376 – LWP Claims Solutions Platinum MPN

Reconozco que he recibido los documentos de compensación al trabajador siguiente:

- Formulario de Reclamo de Compensación para Trabajadores (DWC 1) Y Notificación de Posible Elegibilidad
- Notificación de la Red de Proveedores Médicos (MPN)

Do not cut form

Employee Name /
Su Nombre: _____ SS#: _____

Address /
Dirección: _____

City, St, Zip /
Ciudad, St, Zip: _____

Date of Hire /
Fecha de alquilar: _____ Date of Birth /
Fecha de nacimento: _____

Signature / Firma: **X** _____ **Date / Fecha:** _____

Please provide address of record where we can send you important information as it pertains to your employment with your employer.

Por favor proporcione la dirección del expediente donde podemos enviarle la información importante mientras que pertenece a su empleo con su empleador.

2376 DWC-1 Collaterals 20220418

B.2

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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.

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 beneficios 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.

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.

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 "felonía".

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. *Codigo 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. *Numero 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.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to 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 administradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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 provea 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*

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B.3

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

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B.3

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

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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.

B.4

Important Information about Medical Care if You Have a Work-Related Injury or Illness

Complete Written Employee Notification Re: Medical Provider Network
(Title 8, California Code of Regulations, section 9767.12)

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). The claims for this MPN are administered by LWP Claims Solutions, Inc.

This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

- **What happens if I get injured at work?**

In case of an emergency, you should call 911 or go to the closest emergency room.
If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

- **What is an MPN?**

A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by your employer to treat workers injured on the job. MPNs must allow employees to have a choice of provider(s). Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine.

- **What MPN is used by my employer?**

Your employer is using the LWP Claims Solutions Platinum MPN with the identification number **2376.** You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN.

- **Who can I contact if I have questions about my MPN?**

The MPN Contact listed in this notification will be able to answer your questions about the use of the MPN and will address any complaints regarding the MPN.
The contact for your MPN is:

Name: LWP Claims Solutions, Inc.
Telephone Number: (800) 565-5694

General information regarding the MPN can also be found at the following website: < www.lwpclaimsplatinummpn.com > No password is required to access this MPN

- **What if I need help finding and making an appointment with a doctor?**

The MPN's Medical Access Assistant will help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am-8pm (Pacific) and schedule medical appointments during doctors' normal business hours. Assistance is available in English and in Spanish.

The contact information for the Medical Access Assistant is:
Toll Free Telephone Number: (855)622-6474
Fax Number: (714)892-4825
Email Address: LWPMAA@snp-plus.com

- **How do I find out which doctors are in my MPN?**

You can get a regional list of all MPN providers in your area by calling the MPN Contact or by going to our website at: www.lwpclaimsplatinummpn.com At minimum, the regional list must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You also have the right to obtain a list of all the MPN providers upon request.

You can access the roster of all treating physicians in the MPN by going to the website at: www.lwpclaimsplatinummpn.com

You can access the roster of all participating providers in the MPN by going to the website at: www.lwpclaimsplatinummpn.com

- **How do I choose a provider?**

Your employer or the insurer for your employer will arrange the initial medical evaluation with a MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist**.** Some specialists will only accept appointments with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

- **Can I change providers?**

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your claims adjuster if you want to change your treating physician.

- **What standards does the MPN have to meet?**

The MPN has providers for the entire state of California.

The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

- **What if there are no MPN providers where I am located?**

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your own doctor outside of the MPN network. Contact your MPN Contact for assistance in finding a physician or for additional information.

- **What if I need a specialist that is not available in the MPN?**

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

- **What if I disagree with my doctor about medical treatment?**

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN contact or your claims adjuster and tell them you want a second opinion. The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within 60 days of receiving the regional provider list, you will <u>not</u> be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second-opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.

Remember that if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If you disagree with the third-opinion doctor, you may ask for an MPN Independent Medical Review (IMR). Your employer or MPN Contact will give you information on requesting an Independent Medical Review and a form at the time you select a third-opinion physician.

If either the second or third-opinion doctor or Independent Medical Reviewer agrees with your need for a treatment or test, you may be allowed to receive that medical service from a provider within the MPN or if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

- **What if I am already being treated for a work-related injury before the MPN begins?**

Your employer or insurer has a "*Transfer of Care"* policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician. However, if you have properly predesignated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about predesignation, ask your supervisor.)

If your employer decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer.

If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care into the MPN are set forth in the box below.

Can I Continue Being Treated By My Doctor?

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care) for up to a year if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days;
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with your employer's decision to transfer your care into the MPN. If you don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use an MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the transfer of your care. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process.

For a copy of the Transfer of Care policy, in English or Spanish, ask your MPN Contact.

- **What if I am being treated by a MPN doctor who decides to leave the MPN?**

Your employer or insurer has a written "*Continuity of Care"* policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If your employer decides that you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must choose a MPN physician. These conditions are set forth in the ***"Can I Continue Being Treated By My Doctor?"*** box above.

You can disagree with your employer's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, your employer's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the selection of another MPN doctor for your continued treatment. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the Continuity of Care policy, in English or Spanish, ask your MPN Contact.

- **What if I have questions or need help?**

  - **MPN Contact:** You may always contact the MPN Contact if you have questions about the use of the MPN and to address any complaints regarding the MPN.

  - **Medical Access Assistants:** You can contact the Medical Access Assistant if you need help finding MPN physicians and scheduling and confirming appointments.

  - **Division of Workers' Compensation (DWC):** If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call the DWC's Information and Assistance office at 1-800-736-7401. You can also go to the DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more information about MPNs.

  - **Independent Medical Review:** If you have questions about the MPN Independent Medical Review process contact the Division of Workers' Compensation's Medical Unit at:

    DWC Medical Unit
    P.O. Box 71010
    Oakland, CA 94612
    (510) 286-3700 or (800) 794-6900

Keep this information in case you have a work-related injury or illness.

B.4 - Continued

Información Importante sobre Cuidado Médico si tiene una Lesión o Enfermedad de Trabajo.

Completo Escrito Empleado Notificación Re: Red de Proveedores Médicos
(Título 8 del Código de Reglamentos de California, sección 9767.12)

La ley de California requiere que su empleador le proporcione y pague el tratamiento médico si se lesiona en el trabajo. Su empleador ha elegido a proporcionarle este cuidado médico utilizando una red de médicos de Compensación de Trabajadores llamada Red de Proveedores Médicos (MPN). Sobre las pretensiones de este MPN son administrados por LWP Claims Solutions, Inc.

Esta notificación le indica lo que necesita saber sobre el programa de la MPN y describe sus derechos en la elección de la atención médica de las lesiones y enfermedades relacionadas con el trabajo.

• ¿Qué pasa si me lesiono en el trabajo?
En caso de una emergencia, debe llamar al 911 o vaya a la sala de emergencias más cercana. Si se lesiona en el trabajo, notifique a su empleador tan pronto como sea posible. Su empleador le proporcionará un formulario de reclamo. Cuando le notifique a su empleador que usted ha tenido una lesión relacionada con el trabajo, su empleador o asegurador hará la cita inicial con un médico de la MPN.

• ¿Qué es una MPN?
Una Red de Proveedores Médicos (MPN) es un grupo de profesionales de la salud (médicos y otros proveedores médicos) utilizados por su empleador para tratar a los trabajadores lesionados en el trabajo. MPN deben permitir que los empleados tengan una selección de proveedor (s). Cada MPN debe incluir una combinación de médicos especializados en lesiones relacionadas con el trabajo y médicos con experiencia en áreas generales de la medicina.

• ¿Qué MPN es utilizado por mi empleador?
Su empleador está utilizando el LWP Claims Solutions Platinum MPN con el número de identificación **2376**. Debe mencione el nombre MPN y el número de identificación MPN siempre que tenga preguntas o peticiones sobre la MPN.

• ¿A quién puedo contactar si tengo preguntas sobre mi MPN?
El contacto de la MPN indicado en esta notificación será capaz de responder a sus preguntas sobre el uso de la MPN y abordará quejas con respecto a la MPN.
El contacto para su MPN es:

Nombre: LWP Claims Solutions, Inc.
Teléfono: (800) 565-5694

Información general sobre el MPN también se puede encontrar en la siguiente página web:
www.lwpclaimsplatinummpn.com No se requiere ninguna contraseña para acceder a este MPN

• ¿Y si necesito ayuda para encontrar y hacer una cita con un médico?
Acceso Médico Adjunto del MPN le ayudará a encontrar los médicos disponibles de la MPN de su elección y puede ayudar con la programación y confirmar citas con el médico. El acceso asistente médico está disponible para ayudarle de lunes a sábado de 07 a.m.-8 p.m. (Pacífico) y programar citas médicas

durante las horas normales de negocios de los médicos. La ayuda está disponible en Inglés y en Español.

La información de contacto del Asistente Medical Access es:
Número de teléfono gratuito: (855)622-6474
Fax: (714)892-4825
Dirección de correo electrónico: LWPMAA@snp-plus.com

• ¿Cómo puedo averiguar cuáles médicos pertenecen a mi MPN?
Usted puede obtener una lista regional de los proveedores de la MPN en su área llamando al contacto de la MPN o visitando nuestro sitio web en: www.lwpclaimsplatinummpn.com Como mínimo, la lista regional debe incluir una lista de todos los proveedores de la MPN dentro de 15 millas de su lugar de trabajo y / o residencia o una lista de todos los proveedores de la MPN dentro del condado donde usted vive y / o trabaja. Usted puede elegir qué lista quiere recibir. Usted también tiene el derecho de obtener una lista de todos los proveedores de la RPM que lo soliciten.

Puede acceder a la lista de todos los médicos tratantes en el MPN por ir a la página web en:
www.lwpclaimsplatinummpn.com

Puede acceder a la lista de todos los proveedores participantes en la MPN visitando el sitio web en:
www.lwpclaimsplatinummpn.com

• ¿Cómo elijo a un proveedor?
Su empleador o la aseguradora de su empleador se encargará de la evaluación médica inicial con un médico de la MPN. Después de la primera visita médica, puede continuar siendo tratada por dicho médico, o usted puede elegir otro médico de la MPN. Puede continuar eligiendo médicos de la MPN para todo su cuidado médico para esta lesión.

En su caso, usted puede escoger un especialista o pregunte a su médico tratante que lo remita a un especialista. Algunos especialistas sólo aceptarán citas con una remisión del médico tratante. Tal especialista podría ser catalogado como "sólo de referencia" en el directorio del MPN.

Si necesita ayuda para encontrar un médico o programar una cita médica, puede llamar al Asistente Medical Access.

• ¿Puedo cambiar de proveedor?
Sí. Usted puede cambiar de proveedores dentro de la MPN por cualquier razón, pero los proveedores que elija deben ser apropiados para tratar su lesión. Póngase en contacto con el contacto de la MPN oa su ajustador de reclamos si desea cambiar su médico tratante.

• ¿Qué requisitos debe tener la MPN cumplir?
El MPN tiene proveedores en todo el estado de California.

El MPN debe darle acceso a una lista de proveedores regionales que incluya por lo menos tres médicos de cada especialidad comúnmente utilizados para tratar lesiones / enfermedades en su industria. La MPN debe proporcionarles acceso a médicos de atención primaria dentro de 30 minutos o 15 millas y especialistas dentro de 60 minutos o 30 millas de donde usted vive o trabaja.

Si usted vive en una zona rural o un área donde hay una escasez de atención médica, puede haber un criterio diferente.

Después de haber notificado a su empleador de su lesión, el MPN debe proporcionarle tratamiento inicial

dentro de 3 días hábiles. Si el tratamiento con un especialista haya sido autorizada, la cita con el especialista se debe proporcionar en un plazo de 20 días hábiles de su solicitud.

Si tiene problemas para conseguir una cita con un proveedor dentro de la MPN, comuníquese con el Asistente de Acceso Médico.

Si no hay proveedores de la MPN en la especialidad apropiada para tratar su lesión dentro de los requisitos de distancia y el calendario, entonces se le permitirá buscar el tratamiento necesario fuera de la MPN.

• ¿Qué pasa si no hay proveedores de la MPN donde estoy localizado?
Si usted es un empleado actual que vive en una zona rural o temporal que trabajan o viven fuera del área de servicio de la MPN, o usted es un ex empleado permanente que viven fuera del área de servicio de la MPN, el MPN o su médico tratante le dará una lista de al menos tres médicos que lo puedan atender. El MPN también puede permitirle elegir su propio médico fuera de la red MPN. Póngase en contacto con su MPN para asistencia en la búsqueda de un médico o para información adicional.

• ¿Qué pasa si necesito un especialista que no está disponible en el MPN?
Si usted necesita ver a un tipo de especialista que no está disponible en el MPN, usted tiene el derecho de ver a un especialista fuera de la MPN.

• ¿Qué pasa si no estoy de acuerdo con mi médico sobre tratamiento médico?
Si no está de acuerdo con su médico o desea cambiar de médico por cualquier razón, usted puede elegir otro médico dentro de la MPN.

Si no está de acuerdo con el diagnóstico o con el tratamiento prescrito por su médico, usted puede pedir una segunda opinión de otro médico dentro de la MPN. Si usted quiere una segunda opinión, debe ponerse en contacto con el contacto de la MPN oa su ajustador de reclamos y decirles que quiere una segunda opinión. El MPN debe darle al menos una lista regional o completo proveedor de la MPN de la cual se puede elegir un médico de la segunda opinión. Para obtener una segunda opinión, debe elegir un médico de la lista de la MPN y hacer una cita dentro de los 60 días. Usted debe decirle al contacto de la MPN de su cita, y el MPN le mandará al médico una copia de su historia clínica. Usted puede solicitar una copia de sus registros médicos que serán enviados al médico.

Si usted no hace una cita dentro de los 60 días de recibir la lista regional de proveedores, no se le permitirá tener una segunda o tercera opinión con respecto a este diagnóstico o tratamiento de este médico tratante en disputa.

Si el médico de segunda opinión considera que su lesión está fuera del tipo de lesión que trata normalmente, la oficina del médico le notificará a su empleador o asegurador y usted. Se le enviará otra lista de médicos o especialistas MPN para que pueda hacer otra selección.

Si no está de acuerdo con la segunda opinión, puede solicitar una tercera opinión. Si usted solicita una tercera opinión, usted pasará por el mismo proceso que pasó para la segunda opinión.

Recuerde que si usted no hace una cita dentro de 60 días de recibir la otra lista de proveedores de MPN, entonces no le permitirá obtener una tercera opinión con respecto a este diagnóstico o tratamiento de este médico tratante en disputa.

Si no está de acuerdo con el doctor de tercera opinión, usted puede solicitar una MPN Revisión Médica Independiente (IMR). Su empleador o MPN le dará información sobre cómo solicitar una Revisión Médica

Independiente y un formulario en el momento de seleccionar un médico de tercera opinión.

Si la segunda o tercera opinión médico o Evaluador Médico Independiente está de acuerdo con su necesidad de un tratamiento o prueba, se le puede permitir al recibir el servicio médico de un proveedor dentro de la MPN o si la MPN no contiene un médico que puede proporcionar el tratamiento recomendado, usted puede elegir un médico fuera de la MPN dentro de un área geográfica razonable.

• ¿Qué pasa si ya estoy recibiendo tratamiento por una lesión relacionada con el trabajo antes de que comience la MPN?
Su empleador o asegurador tiene una política de "Transferencia de Cuidado" que determinará si usted puede continuar siendo temporalmente atendido por una lesión relacionada con el trabajo existente por un médico fuera de la MPN antes de que su cuidado sea transferido a la MPN.

Si su médico actual no es o no se convierte en un miembro de la MPN, entonces es posible que tenga que ver a un médico de la MPN. Sin embargo, si usted ha designado previamente un médico para atenderlo, usted no puede ser transferido a la MPN. (Si usted tiene preguntas acerca de la designación previa, pregunte a su supervisor.)

Si su empleador decide transferirlo a la MPN, usted y su médico tratante primario deben recibir una carta notificándole de la transferencia.

Si usted cumple con ciertas condiciones, usted puede calificar para continuar el tratamiento con un médico fuera de la MPN hasta por un año antes de ser transferido a la MPN. Los requisitos para posponer la transferencia de su atención a la MPN se exponen en el cuadro de abajo.

¿Puedo continuar recibiendo tratamiento por mi doctor?

Usted puede calificar para el tratamiento con su proveedor no MPN (por trasferencia de cuidado o continuidad de cuidado) continuar hasta por un año si su lesión o enfermedad cumple alguna de las siguientes condiciones:

• (Agudo) El tratamiento para su lesión o enfermedad se concluirá en menos de 90 días;
• (Afecciones crónicas o graves) Su lesión o enfermedad se considera grave y continúa por lo menos 90 días sin una cura total o empeora y requiere tratamiento continuo. Se le puede permitir ser tratado por su médico actual hasta por un año, hasta que una transferencia segura de la atención se puede hacer.
• (Terminal) Usted tiene una enfermedad incurable o condición irreversible que probablemente cause la muerte dentro de un año o menos.
• (En espera de Cirugía) Usted ya tiene una cirugía u otro procedimiento que ha sido autorizado por su empleador o asegurador que ocurrirá dentro de los 180 días de la fecha efectiva de la MPN o la fecha de terminación del contrato entre la MPN y su médico.

Usted puede estar en desacuerdo con la decisión de su empleador de transferir su cuidado a la MPN. Si usted no quiere ser transferido a la MPN, pregunte a su médico de atención primaria para un informe médico que indique si tiene una de las cuatro condiciones indicadas arriba para poder posponer su transferencia a la MPN.

El médico que lo está atendiendo tiene 20 días a partir de la fecha de su petición para darle una copia de

su / su informe sobre su condición. Si su médico de atención primaria no le da el informe dentro de los 20 días de su petición, el empleador podrá transferir su cuidado a la MPN y estará obligado a utilizar un médico de la MPN.

Tendrá que darle una copia del informe a su empleador si usted desea posponer la transferencia de su atención. Si usted o su empleador no está de acuerdo con el informe de su médico sobre su condición, usted o su empleador pueden disputarlo. Ver la Transferencia de transferencia de cuidado para más detalles sobre el proceso de resolución de disputas.

Para obtener una copia de la transferencia de cuidado, en Inglés o Español, pregúntele a su contacto en la MPN.

• ¿Qué pasa si estoy siendo tratado por un médico de la MPN que decide dejar la MPN?
Su empleador o asegurador tiene una "*continuidad de la atención*" por escrito, la cual determinará si puede continuar temporalmente su tratamiento por una lesión laboral existente con su médico si su médico ya no está participando en la MPN.

Si su empleador decide que usted no califica para continuar su tratamiento con el proveedor fuera de la MPN, usted y su médico tratante primario deben recibir una carta notificándole de esta decisión.

Si usted cumple con ciertas condiciones, usted puede calificar para continuar su tratamiento con este médico hasta por un año antes de que usted debe elegir un médico de la MPN. Estas condiciones son caja establecidos en el "¿Puedo Continuar Ser Tratado Por Mi Médico?" Vea la caja arriba.

Usted puede estar en desacuerdo con la decisión de su empleador sobre negarle la Continuidad de Cuidado con el proveedor de la MPN. Si usted desea continuar el tratamiento con este médico, pregúntele a su médico de atención primaria para un informe médico que indique si tiene una de las cuatro condiciones indicadas en el cuadro de arriba para ver si califica para seguir recibiendo tratamiento de su médico actual.

El médico que lo está atendiendo tiene 20 días a partir de la fecha de su petición para darle una copia de su / su informe médico sobre su condición. Si su médico de atención primaria no le da el informe dentro de los 20 días de su solicitud, la decisión de su empleador sobre negarle la Continuidad de Cuidado con el médico que ya no participa en el MPN se aplicará, y usted tendrá que elegir un MPN médico.

Tendrá que darle una copia del informe a su empleador si usted desea posponer la selección de otro médico MPN para su tratamiento continuado. Si usted o su empleador no está de acuerdo con el informe de su médico sobre su condición, usted o su empleador pueden disputarlo. Vea el plan de transferencia de cuidado para más detalles sobre el proceso de resolución de disputas.

Para obtener una copia de la Continuidad de Cuidado, en Inglés o Español, pregúntele a su contacto en la MPN.

• ¿Qué pasa si tengo preguntas o necesito ayuda?

• Contacto de la MPN: Siempre puede comunicarse con el Contacto de la MPN si usted tiene preguntas sobre el uso de la MPN y hacer frente a las reclamaciones relacionadas con el MPN.

• Asistentes de acceso médica: Puede ponerse en contacto con el acceso auxiliar médico si necesita ayuda para encontrar médicos de la MPN y la programación y confirmar citas.

• División de Compensación para Trabajadores (DWC): Si tiene inquietudes, quejas o preguntas sobre la MPN, el proceso de notificación, o su tratamiento médico después de una lesión o enfermedad de trabajo, puede llamar a la DWC información y Asistencia oficina de la DWC en 1 -800-736-7401. También puede ir a la página web de la DWC en www.dir.ca.gov /dwc y haga clic en "redes de médicos proveedores" para obtener más información sobre las MPN.

• Revisión Médica Independiente: Si usted tiene preguntas acerca de la Revisión Médica Independiente MPN contacto proceso de la División de la Unidad Médica de Compensación de Trabajadores en:

DWC Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 o (800) 794-6900

Guarde esta información en caso que tenga una lesión o enfermedad de trabajo

B.5

EMPLOYERS' MEDICAL TREATMENT AUTHORIZATION

Employee's Name: _____

Employer: **City of Lakeport**

Date of Injury: _____

Part(s) of Body Injured: _____

Employer-Designated treating physician or facility: **Sutter Lakeside Emergency Department, 5176 Hill Rd. E, Lakeport, CA 95453**

_____

Authorized by: _____ Date: _____

Notice to Employee: Please take this form with you to the medical facility indicated above.

Notice to Preferred Provider: This letter will serve as approval for the above named employee to receive initial reasonable and necessary medical treatment required to cure or relieve the effects of injury on an industrial basis. The Claims Administrator indicated below reserves the right to determine reasonable and or necessary further treatment needed on an industrial basis.

Please submit the **Doctor's First Report of Occupational Injury or Illness form 5021** to:

LWP Claims Solutions, Inc.
P.O. Box 349016
Sacramento, CA 95854

Phone: (916) 609-3600
Fax: (408) 725-0395

B.6

Physical Capacity Form

Please e-mail this form to the City of Lakeport at: kbuendia@cityoflakeport.com

Employee Name:	Claim #:	Date of injury:

Please check one of the following:

- ☐ Employee is released to **Full Duty** / regular job as of ____/____/____
- ☐ Employee has **Temporary Restrictions** *as noted below* from ____/____/____ to ____/____/____
- ☐ Employee has **Permanent Restrictions** *as noted below* as of ____/____/____

Physical Capacity

Please note employee's activity capacity as follows:

	No limitation	**CAN** perform this activity as noted below	Can perform on **intermittent basis only**
Sit	☐	hours per day hours at a time	☐
Walk	☐	___ hours per day ___ hours at a time	☐
Stand	☐	___ hours per day ___ hours at a time	☐
Bend (neck)	☐	___ hours per day ___ hours at a time	☐
Bend (waist)	☐	___ hours per day ___ hours at a time	☐
Squat	☐	___ hours per day ___ hours at a time	☐
Climb	☐	___ hours per day ___ hours at a time	☐
Kneel	☐	___ hours per day ___ hours at a time	☐
Twist (waist)	☐	hours per day hours at a time	☐
Twist (neck)	☐	hours per day hours at a time	☐
Simple grasp – RIGHT	☐	hours per day hours at a time	☐
Simple grasp – LEF T	☐	hours per day hours at a time	☐
Power grasp - RIGHT	☐	hours per day hours at a time	☐
Power grasp – LEFT	☐	hours per day hours at a time	☐
Fine manipulation – RIGHT	☐	hours per day hours at a time	☐
Fine manipulation - LEFT	☐	___ hours per day ___ hours at a time	☐
Push / Pull – RIGHT	☐	___ hours per day ___ hours at a time	☐
Push / Pull – LEFT	☐	___ hours per day ___ hours at a time	☐
Reach – BELOW shoulder	☐	___ hours per day ___ hours at a time	☐
Reach – AT/ABOVE shoulder	☐	___ hours per day ___ hours at a time	☐
Lift/Carry – 0 to 5 pounds	☐	___ hours per day ___ hours at a time	☐
Lift/Carry – 6 to 10 pounds	☐	___ hours per day ___ hours at a time	☐
Lift/Carry – 11 to 25 pounds	☐	hours per day hours at a time	☐
Lift/Carry – 26 to 50 pounds	☐	hours per day hours at a time	☐
Lift/Carry – Over 50 pounds	☐	hours per day hours at a time	☐

Is employee restricted from any **environmental factors** such as heat, cold, noise, heights, chemicals, etc?

☐ No ☐ Yes (explain):_____

Other notes/comments:_____

Provider signature: _____ Date:____/____/____

Provider name: _____

B.7

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA _____ EMPLOYER _____

INJURED PERSON NAME _____

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER _____ DATE OF INJURY (YYMMDD) _____

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789. Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP			

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

The following entities comprise the Optum Workers' Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers' Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers' Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers' Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers' Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-2013-11

B.8

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
LWP Claims Solutions, Inc., PO Box 349016, Sacramento, CA 95834 B.8

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
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS: e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY

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)
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: ☐
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)
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
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. Other Workers Injured or Ill in this event? ☐ Yes ☐ No

OR

ILLNESS

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, 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
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
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

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*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
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
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (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.

FORM 5020 (Rev7) June 2002 FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

B.9

Incident Investigation Report Form

See IIPP Attachment E