WORKERS' COMPENSATION PACKET

CALL ALLIED MANAGED CARE (888) 935-2667
WITHIN 24 HOURS OF INJURY

The Medical Provider Network (MPN) can be found at:
https://www.corvel.com/PPOLookupDirect?login=cola

To locate a facility near your location or to verify if a Medical Facility is on the MPN: enter medical facility name, address, or zip code.

Please select the Specialty type:

- Industrial Medicine
- Occupational Medicine
- Occupational Medicine Center
- Occupational Therapy Center

County of Los Angeles
DHS Risk Management
Return to Work Unit

TREATMENT REFERRAL FORM

To be completed by Supervisor

TODAYS DATE:

Doctor/Medical Facility: _____

Address: _____

Phone: _____ **Fax:** _____

This form authorizes you to administer initial treatment to the following employee who has reported an injury which may be work related.

Employee Name: _____ **Employee #** _____

Date of Injury: _____ **Job Title:** _____

Department Name: *Department of Health Services* **Dept. #:** _____

Employee's Work Address: _____

_____

Workers' Compensation Third Party Administrator:	***Sedgwick***
TPA Address:	***P.O. Box 11028***
	Orange, CA 92856
Phone:	***(877) 324-0710***

Employee's Supervisor: _____ **Phone:** _____

Return To Work Coordinator: _____ **Phone:** _____

INSTRUCTIONS TO MEDICAL PROVIDER

1. Complete Patient Status Report and give to Employee to return to Supervisor.
2. Send the original completed Doctor's First Report of Injury to the TPA listed above.
3. **Fax or mail a copy** of the completed Doctor's First Report to the Return to Work Unit.

   Dept. # 110, 113, 115, 120, 160, 200, 225, 260, & 290 @ **(323) 890-8363**
   Mail to: 5555 Ferguson Drive, Suite 200-20, Commerce, CA 90022

   Dept. # 113 **North County Ambulatory Care Network @ (661) 524-2385**
   Mail to: 335 E. Ave I, Area 13A, Lancaster CA, 93535

   Dept. # 240 **Olive View Medical Center @ (747) 210-3310**
   Mail to: 14445 Olive View Drive, Human Resources Building/Room 20, Sylmar, CA 91342

4. Call the TPA at the number listed above immediately to request any of the following during the initial visit:
   *Consultation *Hospitalization * Additional Diagnostic Testing * Physical Therapy
5. Call the Department's Return to Work Coordinator if you have any questions.
6. Send all Medical Bills to the Third Party Administrator listed above.

County of Los Angeles
DHS Risk Management
Return to Work Unit

TREATING PHYSICIAN'S LETTER: Physical Injury

Date: _____

To: Initial Treatment Physician

RE: Injured Worker: _____
(Print name of Injured Employee)

- Our employee has been sent to your office for medical treatment of an injury that may be work-related.
- Enclosed is the Job Description of the injured workers' duties. We would request that a review of his/her job description be made prior to making a decision regarding recovery limitations/work restrictions.
- The County of Los Angeles has a Return-to-Work Program and will attempt to modify the current position or place an injured worker into a temporary assignment. If you have any questions call the Return to Work Coordinator.
- Please use the enclosed Patient Status Report to outline the physical limitations/work restrictions, if any, recommended at this time, as well as the treatment plan.
- All treatment is pursuant to ACOEM Guidelines, and must comply with DWC regulations.
- Payment is according to fee schedule pursuant to Labor Code Section 5307.1 and T8 California Code Regulations 9789.10.
- Reporting must adhere to the requirements of the Division of Workers' Compensation.

Should you have any questions or need to review additional information regarding our program, please contact the County of Los Angeles, Chief Executive Office (CEO) Disability Administration at (213) 351-6411.

Thank you for your full cooperation.

The Patient Status Report needs to be completed prior to the employee leaving your office.

County of Los Angeles
DHS Risk Management
Return to Work Unit

PATIENT STATUS REPORT: Physical Injury

Name: _____ Date of birth: _____ Date of Visit: _____

Job Title: _____ Dept#: _____ Employee #: _____

Claim # _____ DOI: _____ Third Party Administrator: **Sedgwick**

To be completed by Physician

☐ Yes, I have reviewed the employee's Job Description prior to completing work status information (Physician, please check the box).

WORK STATUS *(Check appropriate box and enter date)*

☐ Release to Usual & Customary Position WITHOUT limitations on: _____

☐ Release to Light Duty Assignment with Work Restrictions listed below, effective dates:_____ to _____

☐ Totally Temporarily Disabled Until: _____

RECOVERY LIMITATIONS/WORK RESTRICTIONS

Indicate limitation related to the following activities:		**Check here if No Limitations**
Sitting:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Standing:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Walking:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Lifting/Carrying:		
	Employee can lift/carry up to _____ pounds infrequently.	☐
	Employee can lift/carry up to _____ pounds occasionally.	☐
	Employee can lift/carry up to _____ pounds frequently	☐
	Employee cannot lift/carry more than _____ pounds.	☐
Bending:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Squatting:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Kneeling: Crawling	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Climbing:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Reaching:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Pushing/Pulling:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Gripping/Grasping:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Repetitive Hand use:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐
Fine Finger Manipulation:	Maximum ☐ 2 hrs. ☐ 4 hrs. ☐ 6 hrs. Per day	☐

Other:_____

_____

_____

Can employee have contact with the public? ☐ Yes ☐ No Is he/she employable in any occupation? ☐ Yes ☐ No

TREATMENT PLAN

☐ Follow-up appointment on: _____ ☐ Physical Therapy: _____ time(s) per week for _____ weeks

☐ Medication: _____

Print Physician's Name: _____ Signature: _____ Date: _____

Print Facility's Name: _____ Physician's License #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Complete Patient Status Report and give to Employee to return to Supervisor. Fax a copy of the completed Patient Status Report to the **Return To Work Unit: Please refer to instructions on the Treatment Referral Form.**

Employee#:

Department Code:

Department Number:

State of California
Division of Workers' Compensation
Retraining and Return to Work Unit

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

DWC-AD 10133.33

County of Los Angeles Department of Health Services

INSTRUCTIONS: This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed to determine whether the employee is able to return to work.

EMPLOYEE NAME: (LAST) (FIRST) (M.I.)				CLAIM#:
EMPLOYER NAME:	JOB ADDRESS:			
JOB TITLE:	HRS. WORKED PER DAY:	HRS. WORKED PER WEEK:	SHIFT:	

DESCRIPTION OF JOB RESPONSIBILITIES: (DESCRIBE ALL JOB DUTIES)

Please check one: ☐ Regular Duty ☐ Modified Duty ☐ Alternative Work

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 hours	OCCASIONALLY up to 3 hours	FREQUENTLY 3 - 6 hours	CONSTANTLY 6 - 8+ hours
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck)				
Twisting (waist)				
Hand Use: Dominant hand Right--- Left---				
Is repetitive use of hand required?				
Simple Grasping (right hand)				
Simple Grasping (left hand)				
Power Grasping (right hand)				
Power Grasping (left hand)				
Fine Manipulation (right hand)				
Fine Manipulation (left hand)				
Pushing & Pulling (right hand)				
Pushing & Pulling (left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				
Keyboarding with both hands				

Employee#:

Department Code:
Department Number:

2. Please indicate the daily Lifting and Carrying requirements of the job: Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried .

	LIFTING					CARRYING				
	Never 0 hrs	Occasionally up to 3 hrs	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	Height	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	Distance
0-10 lbs.										
11-25 lbs.										
26-50 lbs.										
51-75 lbs.										
76-100lbs.										
100+ lbs.										

Describe the heaviest item required to carry and the distance to be carried:_____
_____

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	☐	☐	_____
b. Working around equipment and machinery?	☐	☐	_____
c. Walking on uneven ground?	☐	☐	_____
d. Exposure to excessive noise?	☐	☐	_____
e. Exposure to extremes in temperature, humidity or wetness?	☐	☐	_____
f. Exposure to dust, gas, fumes, or chemicals?	☐	☐	_____
g. Working at heights?	☐	☐	_____
h. Operation of foot controls or repetitive foot movement?	☐	☐	_____
i. Use of special visual or auditory protective equipment?	☐	☐	_____
j. Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.	☐	☐	_____

Employee Comments:

Employer Comments:

EMPLOYER CONTACT NAME:	EMPLOYER CONTACT TITLE:
EMPLOYER REPRESENTATIVE SIGNATURE:	DATE:
EMPLOYEE'S SIGNATURE:	DATE:

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

Please complete in triplicate (type if possible) Mail two copies to:
Sedgwick
P.O. BOX 11028 Orange, CA 92856

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
County of Los Angeles, Department of Health Services

1a. Policy Number
N/A

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
N/A, See # 3.

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

5. State unemployment insurance acct.no

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

INJURY OR ILLNESS

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

8. TIME INJURY/ILLNESS OCCURRED
_____ AM _____ PM

9. TIME EMPLOYEE BEGAN WORK
_____ AM _____ PM

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

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

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 INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY

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)
CA

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 Month

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

Completed By (type or print)

Signature & Title

Date (mm/dd/yy)

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

• 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.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

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

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

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to 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 has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same 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.

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

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

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. Se adjunta el formulario 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 se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

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

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar 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 ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

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 se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

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

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

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

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

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

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

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

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

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

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

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

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

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo 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.

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

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov**.**

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, ó consulte con la pagína Web en **www.californiaspecialist.org**.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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 em- ployer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of work-ers' compensation benefits is included as the cover sheet of this form.

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

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

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

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

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

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

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

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

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

9. Name of employer. *Nombre del empleador*. **County of Los Angeles, Dept of Health Services**
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name & address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* **Sedgwick – P.O. Box 11028, Orange, CA 92856**
15. Insurance Policy Number. *El número de la póliza de Seguro.* **XXXXX**
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

07/01/04 Rev.

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

SUPERVISOR'S INVESTIGATION REPORT OF WORK RELATED ILLNESS OR INJURY

(Please Type or Write Legibly)

Injured Employee's Name:	Employee #:	Employee Job Title:
Department:		Division/Unit /Area/Ward:

Date of Injury:	Time of Injury	Work Shift	Exact Accident Location (Indoor - Bldg., Floor, Room #; Outdoor - Parking Lot #, Sidewalk, etc):	Date Injury Reported:
	AM PM	☐Day ☐12-hr Day ☐Evening ☐12-hr Night ☐Night ☐Overtime ☐Intern/Resident		

1. **How did it happen**? Go to scene and reconstruct accident. Ask what happened and how it happened. Attach additional sheets if needed.

2. **Witness(es)**? List Name(s)_____

3. **Cause(s) of the Accident** - What caused the accident? Was it procedure, material, equipment, environment, malfunction, or another cause? List all facts, processes and information of the work being performed and the environment around the employee during the incident.

4. **Corrective Action Taken** - What have you done to prevent future accidents? If applicable, have deficiencies been reported to Maintenance/Facilities Management for repair?

5. **Corrective Action To Be Taken** - How can similar accidents be prevented? Training, repair/maintenance, new equipment, change of procedure, change of attitude, etc. Please describe.

Supervisor Name _____ Tel. _____ Date _____
(Please Print)

County of Los Angeles **Department of Health Services**

EMPLOYEE'S REPORT OF INCIDENT

To be Completed by Employee **(Please write legibly)**

Name:	Employee #:	Job Title:
Department:		

Incident Date:	Time of Incident: AM PM	Work Shift: ☐Day ☐12-hr Day ☐Evening ☐12-hr Night ☐Night ☐Overtime ☐Intern/Resident	Incident Location:	Incident Reported to:

Nature of Injury/Illness (e.g., strain, cut, fracture, dermatitis, multiple injuries etc.):
Specify Body Part Injured (e.g.,left/right arm, lower/upper body, etc.):
Cause of Injury (e.g., machinery, desk, vehicle, person, tool, stairs, ladder, etc.):
Employee's Statement of What Occurred (Attach additional sheets if necessary):
Who Witnessed The Accident? Name and Contact Information? (e.g., phone number, email, etc.):

The above information is true and correct to the best of my knowledge.
Please note: Workers' Compensation claims filed after one (1) year from the date of injury will not be accepted.

Employee's Signature _____ Date _____

Employee#:

Department Code:

Department Number:

County of Los Angeles
DHS Risk Management
Return to Work Unit

RECEIPT OF WORK-RELATED INJURY/ILLNESS PACKET

This packet should be given to the employee when a potential work-related accident or injury/illness has occurred. By signing in the spaces below, the employee and the supervisor acknowledge that the employee has received the *Work-Related Injury/Illness Packet.* This packet is a key component of the County of Los Angeles Return to Work Program and should be completed upon receipt of the packet. It provides the employee with critical information regarding the filing of an industrial injury.

Employee's Signature	Print Name	Date

Supervisor or County Designee Signature	Print Name	Date

Originals must be submitted to the Return to Work Unit.

Employees and Supervisors must retain a copy for their records.

County of Los Angeles
DHS Risk Management
Return to Work Unit

Employee's Statement Declining Medical Treatment

(PLEASE WRITE LEGIBLY)

Employee's Name:_____

Employee's Number:_____ **Date of Injury:**_____

Department:_____

Although I have been offered ☐ first aid ☐ medical treatment / advice, in connection with my injury, I am declining the offer for the following reason(s):

Supervisor or County Designee Signature	Date	Employee Signature	Date

Supervisor or County Designee
(Please Print)

County of Los Angeles
DHS Risk Management
Return to Work Unit

FIRST ALERT

Notice of Possible Industrial Injury or Illness

Date: _____

Fax to: (323) 890-8363 (Commerce)

(661) 524-2385 (High Desert)

(747) 210-3310 (Olive View Medical Center)

Attention: Return to Work Unit

Department Code: _____

Department Number: _____

From: _____ Phone#: _____

Print Employee Name: _____

Employee Number: _____ Date of Injury:_____

Basic Description of Incident:

_____

_____

_____

_____

_____

_____

_____