LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

SUBJECT: WORKPLACE VIOLENCE PREVENTION PLAN **POLICY NO.** 448B

CATEGORY: Safety	**EFFECTIVE DATE:** 7/17
POLICY CONTACT: Yvette Ruiz	**UPDATE/REVISION DATE:**
REVIEWED BY COMMITTEE(S): Environment of Care	

PURPOSE:
To protect all workforce members from workplace violence.

DEFINITIONS:
Workforce Member: Includes employees, contract staff, affiliates, volunteers, trainees, students, and other persons whose conduct, in the performance of work for DHS, is under its direct control, whether or not they receive compensation from the County.

Workplace Violence: Any act of violence or threats that occur at the worksite.

Cal-OSHA Workplace Violence:

(a) the threat or use of physical force against a workforce member that results in (or has a high likelihood of resulting in) injury, psychological trauma or stress, regardless of whether the workforce member sustains an injury

(b) an incident involving the threat or use of a firearm or other dangerous weapon(including the use of a common object as a weapon), regardless of whether a workforce member sustains an injury;

(c) The four types of violence are:

Type 1 Violence: Workplace violence committed by a person who has no legitimate business at the worksite, including violent acts by anyone who enters the workplace with the intent to commit a crime.

Type 2 Violence: Workplace violence directed at a workforce member by a patient, visitor, or other individual accompanying a patient.

Type 3 Violence: Workplace violence against a workforce member by a present or former workforce member.

Type 4 Violence: Workplace violence committed in the workplace by someone who does not work there but has (or is known to have had) a personal relationship with a workforce member.

REVISED: 7/17, 6/19, 7/21, 5/22
REVIEWED: 7/17, 2/18, 6/19, 4/20, 7/21, 5/22

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Joint Commission Workplace Violence:
(a) verbal, written, or physical aggression,
(b) threatening, intimidating, harassing, or humiliating words or actions
(c) bullying
(d) sabotage
(e) sexual harassment or physical assaults involving a staff, licensed practitioners, patients, or visitors
(f) other behavior of concern

Security: Protection of workforce members and property against harm or loss (workplace violence, theft, access to medication, etc.). A security incident can be caused by a person from inside or outside the hospital/clinic.

Hazard Vulnerability Analysis (HVA): A process for identifying potential emergencies and the direct and indirect effects these emergencies can have on a person, hospital, clinic(s), and campus.

POLICY:
At Harbor-UCLA Medical Center, all workforce members are encouraged to report workplace violence to their immediate supervisor, the Safety Officer, and the Los Angeles County Law Enforcement (Sheriff) on-site when an act of violence or a threat of violence occurs at the worksite.

Note: Punitive and retaliatory actions against a workforce member who makes such a report are prohibited.

PROCEDURE:
The following are implemented to ensure the Workplace Violence Prevention Plan and its processes remain effective for all workforce members:

I. **AUTHORIZED PERSONNEL**
Safety Officer

II. **STAFF INVOLVEMENT IN DEVELOPING AND REVIEWING THE PLAN**
Safety Officer, Environment of Care Committee, and any other authorized representatives will be responsible for developing, implementing, and reviewing the plan annually. The Safety Office will also participate in identifying, evaluating, and correcting workplace violence hazards/risks.

III. **COORDINATION WITH OTHER WORKFORCE MEMBERS**
This policy is an addendum to Policy 448 – Injury and Illness Prevention Program (IIPP). Some methods used to inform workforce members of the plan include management bulletins, screensavers, the Environment of Care Committee, the Patient Safety Committee, Harbor's online Policy and Procedure Manual, Environmental, Health & Safety Department On-line SharePoint, and onsite training. The United Health Care (UHC) Safety Intelligence (SI) System will be used as the means for reporting workplace violence incidents as they occur. Workforce members will follow online reporting protocol for incidents including physical force against a workforce member by a patient or a person accompanying a patient that results in (or has a high likelihood of resulting in) injury, psychological trauma, or stress and any other definitions as defined above by Cal-OSHA, Joint Commission or other regulatory agencies.

IV. **LAW ENFORCEMENT ASSISTANCE**
During all shifts, workforce members and/or supervisors can contact the onsite County Sheriff's Department at extension 64450 for law enforcement-related concerns. When reporting an incident, all

workforce members will provide:
a) Location of incident
b) Brief description of disruption and alleged assaulter

V. RESPONSE

Law Enforcement, Safety Office, and/or authorized workforce members will respond to the location of the workplace violence when notified.

VI. WORKFORCE MEMBER COMPLIANCE

Supervisory and non-supervisory workforce members shall comply with the plan in accordance with Title 8, Section 3203(a)(2). The plan ensures all workforce members must comply with safe and healthy work practices.

VII. WORKFORCE MEMBER COMMUNICATION

Procedures to communicate with workforce members regarding workplace violence matters shall include how workforce member(s) will:

a) Document and communicate to other workforce members between shifts and units, information regarding conditions that may increase the potential for workplace violence incidents.
b) Report a violent incident, threat, or other workplace violence concerns via the SI system and directly to the supervisor.
c) Communicate workplace violence concerns without fear of reprisal.
d) Report concerns to be investigated and be informed of the results of the investigation and any corrective actions taken.
e) Report workplace violence matters through the SI and by activating Code Gold, Code Gray, and Code Silver (see Attachment I).

VIII. TRAINING/DRILLS

Harbor shall provide workplace violence prevention and/or other training that addresses the types of violence risks that workforce members can reasonably anticipate or may encounter in their jobs. The Safety Office, Hospital, or Department of Health Services will train authorized representatives by Tier Levels (see Attachment II).

Supervisors must ensure new workforce members are oriented to job-specific policies and procedures related to workplace prevention and duties and responsibilities – depending on the area in which the workforce members work.

The hospital provides new employee orientation, annual re-orientation, and online training which includes workplace violence prevention, emergency codes, how to report, and emergency drills such as active shooter.

IX. ENVIRONMENTAL RISK FACTORS

The Safety Office will report all risk factors quarterly and annually to the Environment of Care, Workplace Violence Prevention and Patient Safety Committees.

a) Environmental risk factors shall include, but are not limited to, workforce members working in locations which:
    i. Are isolated from other workforce members.

ii. Have poor illumination or blocked visibility.
iii. Have a barrier between staff and at-risk patients.
iv. Have Obstacles and impediments to accessing alarm systems.
v. Have alarm systems that may not be operational.
vi. Have entryways where unauthorized entrance may occur.
vii. Contain furnishings or any object that might be used as a weapon.

b) Offsite clinics will follow the same risk factors

X. PATIENT-SPECIFIC RISK FACTORS

Workforce members must identify and evaluate the patient's risk factors including:

a) Patient's mental status
b) Patient's treatment and medical status to include medications
c) Patient's history of violence
d) Disruptive or threatening behavior

XI. CORRECTION OF WORKPLACE VIOLENCE HAZARDS

Designated workforce members, with assistance from the Safety Office, will coordinate the correction of workplace violence hazards by:

a) Ensuring workforce members are trained and available as Safety Champions.
b) Submitting work orders to repair any findings
c) Following up on the environmental rounds report and its findings
d) Providing immediate communication in all areas where patients or members of the public may be present
e) Arranging workspaces including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms as needed to ensure safety measures.
f) Removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons.
g) Enforcing security measures (weapon screening) to prevent the transport or entrance of unauthorized firearms and other weapons into the facility.
h) Installing and maintaining the use of an alarm system.
i) Utilizing the Hospital Incident Command Systems (HICS) in the event of a mass casualty threat or active shooter incident, as described in Harbor's Emergency Management Plan.

XII. WORKFORCE MEMBER'S RESPONSIBILITIES

In the event of a workplace violence incident, workforce members must readily be able to:

a) Consider the 4 stages in the Crisis Cycle to better identify and address potential danger (see Attachment III).
b) Recognize the current stage of a crisis and, when possible, apply knowledge to de-escalate the situation.
c) Maintain situational awareness at all times.
d) Know the **three emergency codes** related to workplace violence **(Code Gold, Code Silver, and Code Gray),** and the appropriate response for each one (see Attachment III).
e) Contact the 24/7 onsite County Sheriff's Department at extension 64450 for law enforcement support/related concerns and be prepared to provide:
    i. Location of incident
    ii. Brief description of disruption and alleged assaulter.
f) Be aware of all exit routes to evacuate with patient(s), visitor(s), and other workforce member(s) when

possible.
g) Once removed from the site of danger, immediately contact the supervisor.
h) Submit SI report, if possible.

XIII. SUPERVISOR'S RESPONSIBILITIES

Procedures for incident response and investigation include but are not limited to the following:

a) Remove everyone from immediate danger.
b) Determine if law enforcement is needed and contact/activate when necessary.
c) Provide immediate care to injured patients, visitors, and workforce members through Harbor's Emergency Department.
d) Identify all workforce members involved in an incident.
e) Obtain affidavit statements from all involved parties (see Attachment V).
f) Initiate and/or complete Security Incident Report (SIR) and SI (See Attachment VI).
g) Make the Employee Assistance Program (EAP) available to all workforce members affected by the incident.
h) Forward all documents (IA, SIR, Affidavit, WPV Reporting Form) and EAP offering results to the Safety Office.
i) Keep and maintain all original documents related to the incident.

All workplace violence reports will be accepted. Supervisors are prohibited from taking any punitive or retaliatory action against a workforce member for seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.

XIV. LAW ENFORCEMENT RESPONSIBILITIES

Procedures during incident response and investigation include, but are not limited to:

a) Responding in a timely manner to ensure the safety of workforce members, patients and visitors.
b) Assisting workforce members during the incident as needed or as requested.
c) Providing the required report(s) to the Safety Office.
d) Entering any other workplace violence incident identified by law enforcement into the SI system.

During normal work hours, notify Hospital Administration and the Safety Office of the incident and outcome. After hours, inform House Supervisor of the incident and outcome. House Supervisor will then alert the Administrator on Duty (AOD) and the Safety Officer.

Law Enforcement Department (Sheriff) and the Safety Office and other departments conduct environment rounds to identify potential risks on the hospital, clinics, campus, and people (internally and externally). Reports are provided to the Safety Office and the Environment of Care Committee for review.

XV. SAFETY OFFICE RESPONSIBILITIES

Procedures for post-incident response and investigation conducted by the Safety Office are to:

a) Conduct a post-incident review when possible.
b) Review any specific risk factors and implement safety measures, if needed.
c) Review whether appropriate corrective measures were followed under the plan and retrain and/or reinforce with workforce member/manager as needed.
d) Maintain the violence incidents log and complete the required sections (see Attachment VII).
e) Complete the workplace violence incident reporting online to Cal/OSHA within the appropriate timeframe.

f) Review all workplace violence events and work closely with the department to reduce risks and reinforce everyone's responsibilities.
g) Participate in the Staff Assault Workgroup Committee to provide data to find methods, processes, trends, or implement activities to reduce workplace violence.

The Safety Office collaborates closely with the on-site Law Enforcement and other departments to assess risks/findings to implement corrective measures to reduce workplace violence. Assaults and other risks are discussed/reviewed in the Environment of Care Committee.

All workforce members' assaults and/or injuries are reviewed.

XVI. AFTER HOURS, WEEKEND AND HOLIDAY REPORTING PROCEDURES

House Supervisor will follow these instructions when a workplace violence incident occurs after hours, on a weekend, or on a holiday:

a) Screen calls and obtain the following information:
   - Name of affected workforce member(s) or visitor(s)
   - Contact information
   - Location of incident
   - Brief description of the event
b) Call Sheriff's at extension 64450
c) After investigating the incident:
   i. Obtain affidavit(s)
   ii. Obtain SIR
   iii. Input SI report for a workplace violence incident.
   iv. Provide any needed medical care to the injured parties through Harbor's Emergency Department and/or selected clinics.
   v. Complete Industrial Accident (IA) report.
   vi. Immediately report the incident to the Administrator on Duty (AOD) and Safety Officer via County email and by telephone with the above information to ensure reportable events are reported timely.
d) When reporting a reportable workplace violence incident to Cal/OSHA:
   i. Always consult with AOD and Safety Officer prior to submitting any report to Cal/OSHA.
   ii. All above materials must be kept in a folder to provide copies to the Safety Officer for further investigation.

ATTACHMENT(S)

I) Emergency Code Summary
II) Workplace Violence Training Requirements
III) Harbor-UCLA Workplace Violence Prevention Plan (WVPP) Brochure
IV) Workplace Violent Incident Hospital Online Report
V) Affidavit
VI) Security Incident Report (SIR)
VII) Industrial Accident (IA) Report
VIII) Workplace Violence Incident Log (Non-reportable and Reportable)

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REFERENCE(S)/AUTHORITY:
Title 8, California Codes of Regulations, Section 3342.
Department of Health Services, Emergency Codes, Policy No.905.000
Title 8, California Codes of Regulations, Section 3203.
Senate Bill No. 1299 Hospital Online Reporting Requirements.
Joint Commission, Environmental Care 02.01.01 Standard

Emergency Code - Summary

Attachment I

CODE Name	Description
CODE BLUE	Adult Medical Emergency
CODE WHITE	Pediatric Medical Emergency
CODE RAPID RESPONSE	Urgent Medical Attention to Inpatients
CODE ASSIST	Urgent Medical Assistance to Outpatients, Visitors, and Staff
CODE GOLD	Mental Health/Behavioral Response
CODE GRAY	Combative Person
CODE SILVER	Person with a Weapon and/or Active Shooter and/or Hostage Situation
CODE ORANGE	Hazardous Material Spill/Release
CODE GREEN	Patient Elopement
CODE PINK	Infant Abduction
CODE PURPLE	Child Abduction
CODE RED	Fire
CODE TRIAGE ALERT	Potential Disaster
CODE TRIAGE EXTERNAL	External Disaster
CODE TRIAGE INTERNAL	Internal Disaster
CODE YELLOW	Bomb Threat

Harbor-UCLA Medical Center Workplace Violence Prevention Plan
Training Requirements

	Tier I		Tier II	
Frequency	Initial	Annual	Initial	Annual
All Employees	X			
Employees with patient contact activities & their Supervisor	X	X		
Employees assigned to respond to Violent incidents or Confronting Aggressive Behavior (Code Gold/Silver/Gray)	X		X	X

Tier I	Tier II
1. Explanation of the WVPP (with details) 2. How to recognize the potential for violence, factors contributing to the escalation of violence and how to counteract, and when & how to see assistance to prevent or respond to violence 3. Strategies to avoid physical harm 4. Emergency codes, alarms, & warnings (including mass casualty threats). How to use identified escape routes or locations for sheltering 5. Role of private security personnel, if any 6. How to report violent incidents to law enforcement 7. Resources available to employees for coping with violent incidents, including EAP & critical incident stress debriefing 8. Interactive questions & answers	1. General and personal measures 2. Aggression & violence predicting factors 3. The assault cycle 4. Characteristics of aggressive & violent patients and victims 5. Verbal intervention and de-escalation techniques & physical maneuvers to defuse and prevent violent behavior 6. Strategies to prevent physical harm 7. Appropriate and inappropriate use of restraining techniques in accordance with Title 22. 8. Appropriate and inappropriate use of medications as chemical restraints 9. Practice the maneuvers and techniques with other employees, including a debriefing on the practice.

* Training does not have to be given in person.

Emergency Codes

Code GOLD (x111) – Initiated when there is an emergency or concern involving a patient's mental state and their potential to bring harm to others or to themselves.

Staff Response:

1. Notify Hospital Operator by dialing x111.
2. Give exact location of patient (clearly differentiate location by using "B" as in boy or "D" as in David).
3. Assist the Behavior Response Team as directed. Patient may be placed in behavior restraints.
4. Remove other occupants (patients/families) as needed.

Code SILVER (x111) – Called when a situation occurs involving an individual with a weapon or who has taken hostage(s) within the facility.

Employee(s) Shall:

1. Notify Hospital Operator by dialing x111 or (424) 306-6200.
2. Give location and brief description of the activity.
3. Escape to a safe place of refuge; help others escape (if possible).
4. Hide out. Prevent an active shooter from entering the hiding space. Barricade yourself in the hiding space.
5. As a last resort, "Take Action" to attempt to disrupt and/or incapacitate the active shooter.

Code GRAY (x64450) – Called when aggressive, combative, violent, or abusive behavior is displayed by a visitor, workforce member, patient, or other individual; and is to be used in the non-clinical management of disruptive behavior.

Staff Response:

1. Notify Sheriff's Department at x64450.
2. Give location and brief description of disruption.
3. Attempt to verbally de-escalate the assailant.
4. Provide assistance to the victims

Incident Reporting

- To report violent incidents immediately, contact Sheriff's at extension x64450.
- Enter all workplace violence incidents into the Safety Intelligence (SI) system by:
  1. Accessing the Harbor Intranet located on all facility computer desktops.
  2. Selecting Safety Intelligence located in the quick links section on the right.
  3. Proceed with entering the requested information and click submit when complete.

For Further Questions:

Harborsafetyhotline@dhs.lacounty.gov

Resources

Employee Assistance Program (EAP)
Licensed mental health professionals are available to assist employees and their dependents with personal or situational stress that interferes with their well-being, day-to-day functioning and carrying out their job responsibilities.
(213)738-4200
http://ceo.lacounty.gov/EAP/

Department of Mental Health
24/7 ACCESS Hotline
Free, confidential mental health information, referrals to service providers and crisis counseling.
(800)854-7771
http://dmh.lacounty.gov/

Harbor-UCLA MEDICAL CENTER

WORKPLACE VIOLENCE PREVENTION PLAN (WVPP)

Attachment III

True North

To Prevent Harm To Our Workforce Members

Harbor's Workplace Violence Prevention Plan

Purpose: To protect Harbor-UCLA workforce members.

What is Workplace Violence?

"Any act of violence or threat of violence that may occur at the work site."

Crisis Cycle

Workplace violence doesn't occur without warning; it is the third of four stages in the Crisis Cycle. Knowing the stages allows you to better identify and address potential danger.

1st Stage	Anxious Person
2nd Stage	Defensive Person
3rd Stage	Person in Crisis
4th Stage	Tension Reduction

1st Stage of Crisis

Anxious Person – Defined by a notable change/increase in behavior. **Behaviors include:** pacing, finger tapping, wringing hands, asking questions, appearing distracted or withdrawn, and increase in vital signs (heart rate, blood pressure, respiratory rate).

Staff response should be supportive with an empathic, nonjudgmental approach. Examples include: Listening, offering reassurance, providing information, and utilizing therapeutic considerations such as:

Personal Space - An area surrounding the body that varies from person to person. Invasion of personal space increases anxiety for everyone and decreases safety. Staff can honor personal space by maintaining at least a leg's length away.

Kinesics - The non-verbal message transmitted by the motion and posture of the body. Staff can decrease anxiety and send a positive message by maintaining an open body posture, interested facial expression, non-threatening gestures, offering eye contact, and by smiling (depending on the situation).

Paraverbal Communication - The vocal part of speech, excluding the actual words used. Staff's should speak with a smooth, calm, and reassuring voice. The voice volume should be controlled and appropriate for the setting.

"Calming words" and a "positive attitude" have the power to calm anxiety, so be aware of your tone of voice, choice of words, and body language.

2nd Stage of Crisis

Defensive Person – Defined by a loss of rationality; sometimes referred to as the verbally abusive stage. **Behaviors include:** yelling, screaming, belligerent language including the use of profanities, and challenging authority.

Staff response should focus on taking control of a potentially escalating situation by setting limits that are simple, clear, reasonable, enforceable, non-challenging, and non-threatening. Staff members should remain calm, start with positive choices, allow the defensive person to blow off steam, remove the audience, and avoid power struggles.

3rd Stage of Crisis

Person in Crisis – Defined by the total loss of rational control that results in a physical acting-out episode. This is sometimes referred to as the physically abusive stage. **Behaviors include:** engaging in dangerous actions and not responding to verbal interventions, hurting self or others placing patient or others in imminent danger such as hitting, kicking, biting, grabbing, pulling, choking or throwing objects.

Staff response should focus on avoiding solo intervention, using non-harmful personal safety techniques to escape, and activating the appropriate emergency code. Physical intervention is used as a last resort when alternative measures have been considered and are ineffective. **Alternative measures include:** continued verbal intervention, setting limits, offering anti-anxiety medication, and continued observation.

4th Stage of Crisis

Tension Reduction – Defined by the decrease of physical and emotional energy where the individual begins to regain control of their emotions; sometimes referred to as the post-crisis stage. **Behaviors include:** apologizing, crying, withdrawing, sleeping, and expressing feelings of remorse.

Staff response should be focused on building a therapeutic rapport with the individual and avoid blaming the individual for their actions. This is accomplished by debriefing with the individual to discover what happened from their perspective, identifying triggers, and contracting on strategies to avoid the behavior in the future. This debriefing can be performed following the acronym "COPING"

Control - Make sure patient is calm
Orient - Orient patient to what just happened
Patterns - What things triggered the crisis again
Investigate - What needs to change to prevent a crisis
Negotiate - Contract to make changes or change behavior
Give - Give back control to the patient

Avoiding Physical Harm

Most violent behavior occurs after warning signs. The following cues are indicators of possible violence approaching:

Verbal Cues

Speaking loudly, yelling, swearing or using a threatening tone of voice

Non-verbal or Behavior Cues	Remember "STAMP"
▪ Poor hygiene or symptoms of intoxication and/or drug abuse ▪ Aggressive or threatening posture ▪ Arms crossed on chest or clenched fists ▪ Heavy breathing, pacing or agitation ▪ A scared look or a fixed stare ▪ Thrown objects or sudden changes in behavior	STAMP stands for the five visible elements of behavior that can indicate a person's potential or likelihood for becoming violent. Staring and eye contact Tone and Volume of voice Anxiety Mumbling Pacing As the risk of violence increases, the number of observable STAMP cues will typically increase.

Note: More cues shown indicate greater risk of violence.

Dress with Safety in Mind

Remove anything you are wearing that can be used as a weapon or grabbed by someone.

- Long hair should be tucked away
- Avoid wearing earrings, necklaces, etc.
- Do not dangle glasses, keys, or name tags from your neck

Maintain Situational Awareness at All Times!

WORKPLACE VIOLENT INCIDENT ONLINE REPORT – March 22, 2017

Hospital facility: dropdown menu **REQUIRED**	**Date of incident:** dropdown menu **REQUIRED**
Hospital representative and contact information: auto populate from hospital pre-registration information	**Time of incident:** dropdown menu **REQUIRED**

1. Who was the aggressor? **REQUIRED** *(check one)*

- ☐ Patient(s)
- ☐ Spouse /partner of patient (current or former)
- ☐ Family of patient
- ☐ Friend of patient
- ☐ Stranger
- ☐ Supervisor/manager
- ☐ Spouse /partner of employee (current or former)
- ☐ Family of employee
- ☐ Friend of employee
- ☐ Co-worker
- ☐ Licensed independent medical provider
- ☐ Former employee
- ☐ Outside vendor
- ☐ Aggressor not listed above

2. Where did the incident occur? **REQUIRED** *(check one)*

- ☐Emergency room
- ☐Urgent care
- ☐Behavioral-health unit
- ☐Surgery
- ☐Labor & delivery
- ☐Radiology & imaging
- ☐Onsite ambulatory outpatient clinic
- ☐Offsite ambulatory outpatient clinic
- ☐Admissions/registration
- ☐Pharmacy
- ☐Inpatient room
- ☐Seclusion/restraint room
- ☐Administrative offices
- ☐Cafeteria
- ☐Kitchen
- ☐Storage room/area
- ☐Hallway
- ☐Stairway
- ☐Waiting room
- ☐Restroom/bathroom
- ☐Break room
- ☐Lobby/reception area
- ☐Parking lot
- ☐Outside premises
- ☐Location not listed above

3. What type of incident occurred? *(check all that apply)* **REQUIRED**

- ☐Biting by aggressor
- ☐Choking
- ☐Grabbing
- ☐Hair pulling
- ☐Kicking
- ☐Punching/slapping
- ☐Pushing/pulling
- ☐Scratching
- ☐Shooting
- ☐Spitting at/on
- ☐Stabbing
- ☐Striking
- ☐Rape/attempted rape
- ☐Unwanted physical sexual contact
- ☐Type of physical force not listed above
- ☐Use of (i.e., assault with) firearm or other dangerous weapon:
  - ☐Gun
  - ☐Knife
  - ☐Furniture/furnishings (e.g., lamp)
  - ☐Medical equipment
  - ☐Other weapon

4. How many employees were injured? dropdown menu (0-25, 25+) **REQUIRED**

5. What types of injuries were known to be sustained? *(check all that apply)* **REQUIRED**

- ☐Death
- ☐Amputation
- ☐Asphyxiation/suffocation
- ☐Burns
- ☐Bruising/abrasion
- ☐Cut/puncture
- ☐Dislocation/fracture
- ☐Head injury
- ☐Internal injury
- ☐Open wound
- ☐Sprain/strain
- ☐Stress/psychological impairment
- ☐Injury type not listed above
- ☐Injury type unknown by the hospital at this time
- ☐ N/A –No known injured employees at this time (Restriction: if checked, no other boxes can be checked)

6. At the time of the incident were any of the injured employees: *(check all that apply)* **REQUIRED**

- ☐On break/lunch
- ☐Arriving/leaving the facility
- ☐Working past scheduled shift
- ☐No special circumstances apply (Restriction: if checked, no other boxes can be checked)
- ☐Don't know specific circumstances (Restriction: if checked, no other boxes can be checked)
- ☐N/A –No known injured employees (Restriction: if checked, no other boxes can be checked)

7. Was the incident reported to the nearest Cal/OSHA Enforcement District Office under Title 8, CCR, Section 342? ☐Yes ☐ No **REQUIRED**

8. Which district office was the incident reported to? If the incident was not reported to a district office, please select N/A. dropdown menu of district offices **REQUIRED**

9. If another employer's employees are affected, describe that employer(s): *(check all that apply)* **REQUIRED**

☐ N/A –No employees of other employers affected (Restriction: if checked, no other boxes can be checked)

☐Contractor providing services to the hospital
If known: Company name_____ Company phone number_____ **(not required)**

☐Emergency services or medical transport personnel
If known: Company name_____ Company phone number_____ **(not required)**

☐ Licensed independent provider
If known Company name_____ Company phone number_____ **(not required)**

☐Vendor
If known: Company name_____ Company phone number_____ **(not required)**

☐Other
If known: Company name_____ Company phone number_____ **(not required)**

☐Don't know the type of employer

10. Did the use of physical force or a dangerous weapon begin while an employee was alone with the aggressor?
☐ Yes ☐ No **REQUIRED**

11. Did the use of physical force or a dangerous weapon begin while an employee(s) was in an isolated area?
☐ Yes ☐ No **REQUIRED**

12. Did the use of physical force or a dangerous weapon begin in a *location* that was unfamiliar or new to the employee(s)? ☐ Yes ☐ No ☐ Don't know if location was unfamiliar or new to employee(s) **REQUIRED**

13. At the time of the use of physical force or a dangerous weapon was any employee *doing a task* that was unfamiliar or new to them? ☐ Yes ☐ No ☐ Don't know if task was unfamiliar or new to employee(s) **REQUIRED**

14. During the use of physical force or a dangerous weapon, was the employee(s) assisted by: *(check all that apply)* **REQUIRED**

☐Internal security
☐Local law enforcement in response to 911 call
☐Hospital emergency response team
☐Nearby employees
☐Assistance provided that is not listed above
☐Employee received no assistance (Restriction: if checked, no other boxes can be checked)

15. If local law enforcement was contacted via 911, what assistance did they provide? *(check all that apply)* **REQUIRED**

☐N/A local law enforcement not called (Restriction: if checked, no other boxes can be checked)
☐Local law enforcement did not respond
☐Officers provided assistance via phone
☐Officers deployed to the scene
☐De-escalated the situation without physically subduing the aggressor
☐Physically intervened and subdued the aggressor(s)
☐Arrested the aggressor(s)
☐Assistance provided that is not listed above

16. Is there a continuing threat to employees due to unresolved engineering, work practice, and/or administrative controls that need to be addressed? ☐ Yes ☐ No **REQUIRED**

17. Which of the following are planned or under consideration for addressing the continuing threat? *(check all that apply)* **REQUIRED**

☐ **Engineering control modifications**

If known, please provide type of engineering control: (not required)
☐Physical layout (incl. accessible escape routes, unimpeded line of sight)
☐Physical access control
☐Physical barriers
☐Alarm system
☐Lighting
☐Monitoring systems (e.g., metal detectors, closed circuit video, mirrors)
☐Removing/securing objects with weapon potential
☐Reducing overcrowding in waiting room
☐Other engineering control modification

☐ **Work practice control modifications:**

If known, please provide the type of control: (not required)
☐Increased staffing levels
☐Added/increased security personnel
☐Additional employee training
☐Implementation or change in buddy system
☐Improved communication among staff about aggressive/violent patients
☐Reduced waiting times
☐Other work practice modification

☐ **Other type of modification**

☐**Further investigation to identify appropriate exposure control measures is in progress** (investigation includes speaking with involved employees)**.**

☐ **N/A –No continuing threat to employees** (Restriction: if checked, no other boxes can be checked)

County of Los Angeles *Department of Health Services*

AFFIDAVIT

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES } ss.

I, _____ Employee Number: _____ working /living at _____, Los Angeles County California, certify through my signature that the statement given below is true and correct to the best of my knowledge and belief: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATE _____ *SIGNATURE* _____

ANY PERSON WHO SIGNS THIS STATEMENT AND WHO WILFULLY STATES AS TRUE ANY MATERIAL MATTER WHICH HE KNOWS TO BE FALSE IS SUBJECT TO THE PENALTIES PRESCRIBED FOR PERJURY IN THE PENAL CODE BY THE STATE OF CALIFORNIA, SEC. 11054 OF THE W. & I. CODE.

WITNESS AND VERIFIED BY	TITLE	DATE

COUNTY OF LOS ANGELES — CHIEF EXECUTIVE OFFICE
OFFICE OF SECURITY MANAGEMENT

SECURITY INCIDENT REPORT

INCIDENT CODE: -Sel (Refer to Code Sheet)

INSTRUCTIONS: A report shall be completed by the person reporting or involved in the incident or their manager (or designee). The completed report shall be delivered to the Office of Security Management, 500 West Temple Street, Room #785, Los Angeles, California 90012, or sent electronically to osm@ceo.lacounty.gov (*e-mail*) or (213) 613-0848 (*fax*) no later than the end of the business day following the incident.

Refer to accompanying *Incident Code Reference Sheet* for determining proper incident code. Use a separate form(s) to report multiple, individual incidents. Call the Office of Security Management at (213) 974-7926 or visit our website at ceo.lacounty.gov/osm for additional information.

A *SECURITY INCIDENT* IS DEFINED AS:

- An incident placing a person or property at risk that requires action by law enforcement authorities or security personnel at a County facility whether they were summoned or not; or
- An incident placing a person at risk involving an on-duty County employee while on County property or during the performance of their official duties. This classifications includes while walking to or from an off-site parking facility at the start or end of the workday; or
- An incident of a suspicious or unusual nature on County property that places people or property at risk; or
- An incident that occurred during non-business hours that impacts or affects the County workplace.

DATE OCCURRED: / / TIME OCCURRED: _____ DATE SIR COMPLETED: / /

COUNTY DEPARTMENT REPORTING INCIDENT: - Select -

ADDRESS OF FACILITY: _____

ADDRESS OF INCIDENT: *(if different)* _____

SUMMARY OF INCIDENT: *(Briefly describe the incident)*

☐ *Continued on separate sheet*

☐ Law enforcement agency responded

☐ A complaint/criminal report was taken by law enforcement

Agency Name: _____ Report Number: _____

☐ The VICTIM is a County employee

☐ The SUSPECT is a County employee

☐ There was a PHYSICAL ACT of violence

☐ There was a verbal/written THREAT of violence

SAFETY PLAN: The actions below should be considered when dealing with an act of violence or threat if necessary. *(Check all that apply)*

☐ 1) On site security notified

☐ 2) Parties involved were separated

☐ 3) Offer/obtain medical treatment for affected employee

☐ 4) Offer security escort to their vehicle/modify parking assignment

☐ 5) Offer employee reassignment/alternate workplace

☐ 6) Offer County Employee Assistance Program (EAP) services

☐ 7) Law enforcement Patrol Check requested for employee(s) workplace/residence

☐ 8) Obtain and attach copies of written witness affidavits/statements

☐ 9) Emergency Protection Order obtained from law enforcement

☐ 10) Consult with the Office of Security Management (OSM)

☐ 11) Request assistance in obtaining Restraining Order from the Office of County Counsel at (213) 974-8394

☐ 12) Initiate an incident Event Log *(per DHR 620)* to be maintained by: _____

☐ Other action(s) taken: _____

REPORTED BY: _____ TELEPHONE: _____ EMAIL: _____

MANAGER: _____ TELEPHONE: _____ EMAIL: _____

PRINT REPORT

CODE REFERENCE SHEET FOR SECURITY INCIDENT REPORTS

DO NOT SUBMIT THIS FORM WITH YOUR REPORT

A. BURGLARY: *Entering a closed building or locked vehicle with the intent to commit a theft.(459 PC)*

1. Burglary of County owned or leased property
2. Burglary of private property

B. ROBBERY: *The taking of property by force or fear (211 PC)*

1. Robbery of a County facility or employee in the performance of their duties
2. Robbery of a person, including employee, not performing their duties

C. ARSON: *The intentional setting fire to any object (451 PC)*

1. Arson of County owned or leased property
2. Arson of private property

D. SEXUAL ASSAULT: *A term which covers a range of crimes, including rape; non-consensual sex (261 PC)*

1. Rape of a County employee
2. Rape of someone other that a County employee
3. Other sex-related incident

E. ASSAULT: *The physical battering of another person (242 & 245 PC)*

1. Assault with a weapon
2. Assault without a weapon requiring medical attention
3. Assault with only minor or no injuries and no weapon used

F. THEFT: *The unlawful taking, keeping, or using of another's property without permission (including vehicles)*

1. Theft of County owned or leased property
2. Theft of private property

G. DISTURBANCE: *The disruption of routine business*

1. Disturbance of a County facility or employee while performing their duties
2. Disturbance created by a County employee, relation, or domestic partner
3. Disturbance not involving County employee(s).
4. Inappropriate communication

H. THREAT: *Expressed or implied threat of violence or harm*

1. Bomb threat
2. Suicide threat
3. Threat on a County owned or leased facility or event *(not "Bomb Threat")*
4. Physical, verbal, or written threat to a County employee.

I. VANDALISM: *Intentional damage to property (excluding "Arson").*

1. Vandalism to County owned or leased property
2. Vandalism to private property

J. SUSPICIOUS ACTIVITY: *Unusual behavior/activity*

1. Suspicious activity by a County employee
2. Suspicious activity by a non-County employee
3: Suspicious package

K. ILLNESS OR INJURY: *Not resulting from criminal activity (see "Assault").*

1. Rescue responded
2. First Aid administered, no rescue responded
3. Person(s) refused treatment

L. CONTRABAND: *Confiscation of illicit items*

1. Weapon (i.e., gun, knife, club, etc.)
2. Narcotics (including non-prescription drugs)
3. Other types of contraband (specify)

M. MISCELLANEOUS: *Non-criminal activities*

1. Power or equipment failure
2. Lost County identification card
3. Lost badge (metal, shield-type only; not an ID card)
4. Lost County property
5. Alarm activation or response, co crime occurred (Fire, Burglary, Panic...)

N. TRAFFIC ACCIDENTS: *Non-criminal accidents*

1. Involving County owned or leased vehilce(s)
2. Involving private vehicles(s)

O. OTHER: *Acts/activities not covered in any of the previous classifications*

1. Other activity (explain in detail)

(Revised 2012/01/01)

WORKERS' COMPENSATION PACKET

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

The Medical Provider Network (MPN) can be found at:
http://www.alliedmanagedcare.com/mpn

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:	***Tristar Risk Management***
TPA Address:	***P.O. Box 11967***
	Santa Ana, CA 92711-1967
Phone:	***(800) 377-3487***

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 a copy** of the completed Doctor's First Report to **Return to Work Unit** at **(323) 890-8363 or** Mail to: **5555 Ferguson Drive, Suite 200-20, Commerce, CA 90022**

   Dept. # 110, 120, 160, 200, 201,& 290: **(323) 869-7124**
   Dept. # 160, 161, 225, & 226: **(323) 890-7124**
   Dept. # 130, 240, 241:**(661) 471-4459 Fax #: (818) 364-3310**

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
To be completed by Physician

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

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

Claim # _____ DOI: _____ Third Party Administrator: **Tristar Risk Management**

☐ 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: Choose
Department Number: Choose

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#: 2000 - -
EMPLOYER NAME:	JOB ADDRESS: Choose a Location		
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				

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:
Tristar Risk Management
P.O. Box 11967, Santa Ana, CA 92711-1967

Employee #:

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)
Choose an Address

2a. Phone Number

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

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 ☐ X 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)

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
Item #:

38. GROSS WAGES/SALARY
$ _____ per _____

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

Completed By (type or print)

Signature & Title

Date (mm/dd/yy)

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

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

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)

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

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

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

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

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

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 "felonia".

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

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

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

9. Name of employer. *Nombre del empleador.* County of Los Angeles, Department of Health Services
10. Address. *Dirección.* Choose a Location
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    Tristar Risk Management - P.O. Box 11967, Santa Ana, CA 92711-1967
15. Insurance Policy Number. *El número de la póliza de Seguro.* N/A
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*

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:
Choose a Location	

Date of Injury:	Time of Injury	Work Shift	Exact Accident Location (Indoor - Bldg., Floor, Room #; Outdoor - Parking Lot #, Sidewalk, etc):	Date Injury Reported:
	_____	☐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: Choose a Location		

Incident Date:	Time of Incident: _____	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

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: Choose a Location

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)

(818) 364-3310 (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:

_____

_____

_____

_____

_____

_____

_____

CALOSHA Assault Rpt														
Ref	Who was affected by the event?	Reported date	Event occurrence date	Event occurrence time	HCO ID	Site Name	Department	Location / Service Name	Event Type	Event Category	Event Subcategory	Harm score	Description	Mgr Review: Is t… assault or…
HU-18-01-001														
HU-18-01-R01														

his event related to an violent act?	Mgr Review: If Yes: Who committed the violence or assault?	Mgr Review: If Yes: Who committed the violence or assault? -other-	Mgr Review: If Yes: What was the circumstances at the time of the incident?	Mgr Review: If Yes: What was the circumstances at the time of the incident? -other (Specify)	Mgr Review: If Yes: Where did the incident occur?	Mgr Review: If Yes: Where did the incident occur? - other (Specify)	FLR: Type of incident	FLR: Type of incident - other (Specify)	Physical attack	FLR: Type of incident - Physical attack - other (Specify)	Attack with weapon or object	FLR: Type of incident - Attack with weapon or object - other (Specify)	Sexual assault or threat	FLR: Type of incident - Sexual assault or threat - other (Specify)	Patient/Staff:

Received treatment?	FLR: Did anyone provide necessary assistance to conclude the incident?	FLR: If Yes: Who provided necessary assistance to conclude the incident?	FLR: Was security or law enforcement contacted?	FLR: If Yes: Whom was contacted?	Mgr Review: Did the employee take time off work?	Mgr Review: If Yes: How long did the employee take time off work?	Mgr Review: Is there a continuing threat to employees?	Mgr Review: if Yes: Actions taken to protect employees:	Post-Incident Responce	WPV Injury Investigation