

CEA Step By Step Workers' Compensation Guide for Employers in California



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Employers
Association

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TABLE OF CONTENTS

A SNAPSHOT VIEW OF REPORTINGS PROCEDURE FOR CLAIMS	5
Step 1: Initial Knowledge of Injured Worker.....	5
Step 2: Obtain Medical Treatment	5
Step 3: Conduct an Investigation.....	5
Step 4: Claim Handling and Reporting	5
Step 5: Return to Work Authorization	5
Step 6: The Interactive Process	5
WORKERS' COMPENSATION	6
What Is A Work-Related Injury?	6
Accident Reporting	6
What To Do If Someone Is Injured Or Becomes Ill at Work	7
Claim Handling And Reporting Procedures – First Aid Only	8
What Is First Aid Treatment?.....	8
First Aid Work Injury and Illness Reporting.....	9
Claim Handling and Reporting Procedures – Non-First Aid.....	9
What Treatment Is Not Considered First Aid?.....	9
Non-First Aid Work Injury Reporting.....	10
BENEFITS	11
Medical Care	11
Temporary Total Disability	12
Permanent Disability	12
Death Benefits	12
Disability Management	13
Wage Statement	13
Physician's Visit.....	13

Time off From Work.....	13
Returning from Leave of Absence	14
Health Benefits While On Workers' Compensation Leave.....	14
FREQUENTLY ASKED QUESTIONS.....	15
What Constitutes Notice of a Worker's Compensation Claim?	15
When The Employer Has Notice Of A Claim, What Are The Paperwork Steps?.....	15
How Can An Employer Manage a Workers' Compensation Claim?	15
What Happens If The Employee Does Not Turn In The Employee Claim Form?.....	16
Where Does The Employee Receive Medical Treatment?.....	16
Can an Employee Change Medical Providers?	16
When Can The Employee Return To Work?	16
Can an Employee Work Light Duty?	16
What Happens If There Is A Question Whether The Injury Is Job Related?	17
What Can I Do If I Think This Is A Fraudulent Claim?.....	17
What Does Permanent And Stationary Mean?	17
Can An Employee Out On Disability Be Terminated?	18
What Happens If An Employee Gets An Attorney?.....	18
When Does A Workers' Compensation Claim Close?	18
FRAUD AND ABUSE.....	19
How to Reduce Or Prevent Workplace Fraud.....	19
CAL-OSHA – OCCUPATIONAL SAFETY & HEALTH UNDER CALIFORNIA LAW.....	21
Cal-OSHA Recording Requirements	21
Recording Work-Related Injuries And Illnesses.....	21
Which Work-Related Injuries And Illnesses Should You Record?	21
Required Records.....	21
Recording The Incident.....	22
Cal-OSHA Reporting Requirements	23

Reporting Serious Injury Or Death	23
Reportable Incident Procedures	23
Preparing The Annual Summary Of Work-Related Injuries And Illnesses	24
Maintaining Your Work-Related Injury And Illness Records	25
Accessing Work-Related Injury And Illness Records.....	25
APPENDIX A	27
Pre-Designation of Personal Physician	28
Report of Injury Form	29
Supervisor’s Accident Investigation Report.....	31
Employee’s Claim for Workers’ Compensation Benefits (DWC-1 Form)	32
Employer’s Report of Occupational Injury or Illness, Form 5020	33
APPENDIX B.....	34
Return To Work Policy (Sample).....	34
Job Placement.....	34
Responsibilities	35
Supervisors/Managers.....	35
Employees.....	36
The Designated Company Representative	36
APPENDIX C.....	38
Injury And Illness Incident Report – Form 301	39
Work-Related Injuries And Illnesses Log – Form 300.....	40
Summary Of Work-Related Injuries And Illnesses – Form 300a.....	41
DISCLAIMER.....	42

A SNAPSHOT VIEW OF REPORTINGS PROCEDURE FOR CLAIMS

STEP 1: INITIAL KNOWLEDGE OF INJURED WORKER

- Timely and appropriate treatment helps employees return to work quickly.
- Determine if the reported injury requires First Aid treatment only or is a Recordable Injury
- If injury is Recordable, go to Step 2.

STEP 2: OBTAIN MEDICAL TREATMENT

- Determine whether the injured employee should receive care from a clinic or a hospital.
- Determine if employee has a pre-authorization request
- Get employee medical treatment
- Designate the employee's leave, if applicable

STEP 3: CONDUCT AN INVESTIGATION

- An investigation report should be completed within 24 hours of an injury to obtain the following information:
 - Facts about the circumstances of the injury and sequence of events
 - Witnesses
 - Timeliness of employee reporting injury
 - Why did it happen?
 - Prevention of similar incidents

STEP 4: CLAIM HANDLING AND REPORTING

- Reporting Claims and Form Completion
- Complete Employer's First Report of Injury
- The timeliness of the employer's report affects the claims examiners' investigation periods
- Give employee any state specific claim forms if required and/or any employee rights notifications within 24 hours

STEP 5: RETURN TO WORK AUTHORIZATION

- Complete a description of job duties for doctor and employee
- Be responsive to the injured employee's needs
- Determine if employee requires time off from work
- Provide employee with copy of the return to work policy

STEP 6: THE INTERACTIVE PROCESS

- Keep the lines of communication open between employer and employee
- Read through entire Workers' Compensation Step by Step Guide

WORKERS' COMPENSATION

All eligible employees and subsidiary employees are entitled to Workers' Compensation benefits without regard to an employee's race, color, sex, ancestry, sexual orientation, national origin, age, marital status, veteran status, pregnancy, physical disability, mental disability, medical condition, or religion for any work-related injury or illness. This Step by Step Guide provides information to assist an Employer in managing their workers' compensation claims.

WHAT IS A WORK-RELATED INJURY?

A work-related injury or illness may be physical or mental in nature. In order to receive Workers' Compensation benefits, there must be medical substantiation that an injury or illness has occurred and that it is work-related.

There are two types of Workers' Compensation injuries:

- A "specific" injury involves a single traumatic event that has caused the injury or disability. The date of this specific injury is very important in determining benefits.
- A "cumulative trauma" injury involves multiple events or micro-trauma occurring over time, which has caused the injury or disease. The date of this injury is the date the employee last suffered the exposure or obtained knowledge that they have suffered a cumulative trauma injury or suffered disability.

ACCIDENT REPORTING

California Workers' Compensation law requires that the employee report any work-related injury immediately to their employer. Often, injuries are not reported in a timely manner. No matter when the injury occurred, once reported to the employer there are several key steps for the employer to perform. The purpose of this guide is to walk employers through those steps.

California Workers' Compensation law sets forth these reporting deadlines:

- The Employee Claim for Workers' Compensation Benefits Form, DWC-1 Form (see Appendix A), must be provided to the worker within 24 hours employer's knowledge of injury and disability beyond first aid.
- The Employer's Report Occupational Injury or Illness, Form 5020 must be filed within 5 calendar days of employer knowledge.
- A benefit letter and/or disability check must be mailed by the insurance company or claims administrator within 14 days from:
 - the first day of lost time
 - the first day of additional lost time after returning to work.

Stay involved and maintain an open dialogue with the employee and the carrier's claims administrator – do not assume the claims administrator is taking care of everything.

CLAIM HANDLING AND REPORTING PROCEDURES – FIRST AID ONLY

When an employee reports a minor work injury or illness that does not require a doctor visit or time off from work, the designated company representative should follow-up to determine if there was extensive treatment provided, or simply First Aid.

WHAT IS FIRST AID TREATMENT?

First aid cases do NOT need to be recorded. If the incident required only the following types of treatment, consider it first aid:

- using non-prescription medications at non-prescription strength;
- administering tetanus immunizations;
- cleaning, flushing, or soaking wounds on the skin surface;
- using wound coverings, such as bandages, BandAids™, gauze pads, etc., or using SteriStrips™ or butterfly bandages;
- using hot or cold therapy;
- using any totally non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.;
- using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, or back boards);
- drilling a fingernail or toenail to relieve pressure, or draining fluids from blisters; using eye patches;
- using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye;
- using irrigation, tweezers, cotton swab or other simple means to remove splinters or foreign material from areas other than the eye;
- using finger guards;
- using massages;
- drinking fluids to relieve heat stress.

(There are significant requirements for CA employers relating to heat stress and heat illness that are not covered here.)

Additional guidance on what the Department of Industrial Relation's determines as first aid can be found at this link: https://www.dir.ca.gov/t8/14300_7.html.

FIRST AID WORK INJURY AND ILLNESS REPORTING

1. If an employee reports a minor work injury or illness that does not require a doctor visit or time off from work, the supervisor should refer the employee to the designated company representative along with the Report of Injury Form (see Appendix A).
2. Should the injury occur after normal working hours, the supervisor should refer the employee to the designated company representative.
3. If medical attention is required off site, the supervisor should refer the employee to the designated company representative along with the Report of Injury Form (see Appendix A). The employee may be referred to the appropriate medical facility.
4. The Supervisor's Accident Investigation Report (see Appendix A) should be completed by the employee's supervisor and forwarded to the designated company representative.
5. The designated company representative will follow-up to determine if there was extensive treatment provided, or simply First Aid.
6. If, at a later date, more treatment or time away from work is necessary, the designated company representative will report the injury to the Workers' Compensation insurance company.

CLAIM HANDLING AND REPORTING PROCEDURES – NON-FIRST AID

WHAT TREATMENT IS NOT CONSIDERED FIRST AID?

The following does NOT constitute First Aid:

- Lost time away from work beyond date of injury of one hour or more on anyone occasion.
- Physical therapy or chiropractic care is provided.
- Any fracture or severe strain/sprain is sustained.
- Treatment beyond one office visit is required.
- Any diagnostic tests other than X-rays are provided.
- Potential surgery or permanent disability occurs.

NON-FIRST AID WORK INJURY REPORTING

1. If the injury appears to be serious, call 911 immediately for assistance! Then, notify the designated company representative.
2. If the injury does not appear to be serious, please send employee to the designated company representative to complete the necessary forms and for medical referral, as appropriate.
3. The Supervisor's Accident Investigation Report (see Appendix A) should be completed by the employee's supervisor and forwarded to the designated company representative within 24 hours of the incident.
4. The designated company representative and the injured employee will complete the Employee's Claim for Workers' Compensation Benefits Form (DWC-1 Form) (see Appendix A). The designated company representative will also provide the "Facts about Workers' Compensation" pamphlet to the employee.
5. The designated company representative will investigate circumstances surrounding all work-related injuries/illness. Details on description of injury, body parts involved and the names of any witnesses will be provided to the Workers' Compensation insurance carrier.
6. The designated company representative is required to contact the Workers' Compensation insurance company to report any serious injury within five (5) days. If the employee is hospitalized, the report must occur within 24 hours. A fatality must be reported within eight (8) hours.

BENEFITS

MEDICAL CARE

The employer is responsible for "all reasonable and necessary expenses to cure and relieve from the effects of the injury." This will include treatment provided by doctors, chiropractors, physical therapy, hospitals as well as medication and diagnostic tests. The injured worker is also entitled to receive travel expenses (i.e. mileage reimbursement designated by the California Workers' Compensation regulations) to obtain medical care. There are no deductibles, co-payments and no financial maximums on medical care. Any reimbursement for travel expenses should be coordinated with the Workers' Compensation insurance carrier.

California's Workers' Compensation law allows the employer to direct the injured worker to a medical facility of the employer's choice for the first 30 calendar days after an injury. However, the employee has a right to pre-designate their personal physician or medical group to be treated for any work-related injuries or illnesses prior to the filing of the Workers' Compensation claim. The employee must have provided the pre-designation prior to the injury occurring.

As an employer, you have options in managing the medical care of your employees injured on the job. These options include the following:

- Sending the injured employee for medical care to a contracted occupational physician or clinic that specializes in the treatment of occupational injuries and illnesses.
- Sending the injured employee for medical care to their personal physician or medical group.

The employee has a right to exercise a one-time option during the life of the Workers' Compensation claim to change the treating physician. The option must be initiated through the designated company representative, and given in writing to the Workers' Compensation insurance carrier.

Employers are limited in their ability to get second opinions concerning medical care and disability but may elect to request the employee go through the QME (Qualified Medical Examiner) process instead. Employers interested in proceeding with a QME should work with their Workers' Compensation insurance carrier assigned adjuster to fully understand this option.

Many Workers' Compensation insurance companies have developed cost cutting programs to help control medical expenses. One such program is designated by the use of Medical Provider Network (MPN) facilities. These practitioners provide quality medical care and discounts below the Official Medical Fee Schedule. Medical Case Managers may also be used to help the injured worker and medical provider reach a consensus on care and return to work. Employers are encouraged to ascertain if their Workers' Compensation insurance carrier has such a program and if it may be utilized.

TEMPORARY TOTAL DISABILITY

If the injured worker is medically unable to work in any position for the company or its subsidiaries, they may be entitled to compensation from the Workers' Compensation insurance company in the form of temporary disability cash payments. The compensation is calculated at two-thirds of the average weekly wage, up to a maximum based on the date of injury. These payments are tax-free, usually made bi-weekly on a seven-calendar day basis and will continue as long as employee is temporarily disabled. Information as to rates for temporary (and permanent) disability payments can be found at the Department of Industrial Relations website: <http://www.dir.ca.gov/dwc/workerscompensationbenefits.htm>.

The first three full calendar days of disability are considered a waiting period.

If an employee can return to work in a modified or alternate capacity, but at a reduced weekly income, the Workers' Compensation insurance carrier may pay two-thirds of the difference in earnings up to the maximum weekly rate.

PERMANENT DISABILITY

When an injured worker reaches a point where their medical condition is not improving but not getting worse, their condition is called “permanent and stationary” (P&S). This is referred to as the point in time when they have reached maximal medical improvement (MMI). After appropriate medical evaluation, a permanent disability rating will be established to describe the permanent residual in percentages based on a formula that evaluates the disability, the employee's occupation and the employee's age.

An injured worker may receive a rating from 1% to 100% Permanent Disability. Each percent corresponds to a set number of weeks of payments. The rate of each payment is calculated at two-thirds of average weekly pay but with differing maximums based on date of injury and percentage of the disability (cf., link above for payment amounts for permanent disability). Partial permanent disability may allow an injured worker to perform modified duty with reasonable accommodation.

DEATH BENEFITS

Burial expenses are reimbursed up to \$10,000 for a work-related death. Death benefit payments are made to dependents of the deceased employee and are calculated based on whether they are a full or partial dependent as defined by law.

These benefits may total \$320,000 based on the number and types of dependents. In addition, dependent minor children receive payments until they reach their 18th birthday. If a child is physically or mentally incapacitated, benefits continue until the child's death.

WAGE STATEMENT

A wage statement or salary history is required for a lost time claim where the injured employee is making less than \$735 per week. This history should go back at least three months, and up to twelve months, to determine the employee's earning history. If the employee worked less than 30 hours per week, the Workers' Compensation insurance company will also request a wage statement from the employee. This will help the Workers' Compensation insurance carrier to determine the appropriate compensation.

PHYSICIAN'S VISIT

Employees with work-related injuries or illness may seek medical attention from the physician of record in the Workers' Compensation claim. Employees may use sick or vacation/PTO time to receive payment during their physician's visit. An employer may require employees to schedule all medical appointments at the beginning or end of their work schedule wherever feasible.

Upon conclusion of a work-related physician's visit, it is the employee's responsibility to return to work in a timely fashion. The employee must provide a report from the physician indicating their ability to work with or without restrictions and/or accommodations to their immediate supervisor with a copy to the designated company representative. This must be done prior to the employee performing any work-related activities. Supervisors may request the employee to provide advance notice of all scheduled physician or physical therapy appointments.

TIME OFF FROM WORK

If the physician sends the employee home for a work-related injury or illness, the employee should be told they must immediately contact and inform their immediate supervisor and the designated company representative. A copy of the written physician's order placing the employee off work must be sent to the immediate supervisor and the designated company representative via email, facsimile or first class U.S. mail as soon as practicable. The designated company representative will forward the physician's order to the Workers' Compensation insurance carrier who in turn will determine whether or not the employee is entitled to compensation and how much. This is especially important once the employee has returned to work to prevent overpayment.

If the injured employee is off due to a work-related disability, the immediate supervisor should promptly notify the designated company representative. For all approved Workers' Compensation leaves of absence, the supervisor should code the time off in the time reporting system as "Industrial Injury."

The Workers' Compensation insurance company will make regular contact with the treating doctor and injured employee. When written information is slow in coming from the doctor, the Workers'

Compensation insurance company will send out a "Work Status Report" form to be completed by the doctor's office.

RETURNING FROM LEAVE OF ABSENCE

When an employee is released to return to work with or without work restrictions, he or she must report to their immediate supervisor and the designated company representative with a copy of the doctor's release **prior** to the beginning of their work shift.

The employee's immediate supervisor and the designated company representative will review all return to work slips carefully to evaluate if there are any restrictions or preclusions and to determine whether or not the restrictions or preclusions can be accommodated.

HEALTH BENEFITS WHILE ON WORKERS' COMPENSATION LEAVE

Employers who are not subject to FMLA/CFRA (under 50 employees) may not be required to maintain health benefit coverage while an employee is on Workers' Compensation leave. They may terminate coverage and issue a notice of COBRA eligibility.

Employers who are covered under FMLA/CFRA should begin by notifying an eligible employee they are being placed on FMLA/CFRA leave that will run concurrently with their Workers' Compensation leave. Health benefits will continue for the period of the FMLA/CFRA leave in the same manner as if the employee was still working. Employees are responsible for premium co-payments, if applicable. Once FMLA/CFRA is exhausted, the employee may be provided notice of COBRA/Cal-COBRA rights.

FREQUENTLY ASKED QUESTIONS

The following is a brief discussion of the questions that are typically asked about the Workers' Compensation process by employees and supervisors.

WHAT CONSTITUTES NOTICE OF A WORKER'S COMPENSATION CLAIM?

The employer must have knowledge that an injury, illness or death has occurred and it is related to the job. The definition of employer is anyone in a supervisory or management position. This notice can be by any of the following:

- Employee reports incident to supervisor in person, in writing, or by phone
- Supervisor witnesses incident
- The medical provider advises the employer of the incident
- The employee's legal representative files a claim form with the employer

Just a report of an incident does not constitute notice of a claim but should initiate an investigation from the employer.

WHEN THE EMPLOYER HAS NOTICE OF A CLAIM, WHAT ARE THE PAPERWORK STEPS?

- The supervisor should immediately complete the Report of Injury form, paying particular attention to body parts injured and witnesses.
- The designated company representative will initiate completion of the Employee Claim for Workers' Compensation Benefit Form (DWC-1 Form), procedure within one working day of the employer's knowledge on all claims.
- If there is indication the employee will need to see a medical doctor or lose time from work, the designated company representative will complete the Employer's Report of Occupational Injury or Illness Form, Form 5020, and send to the Workers' Compensation insurance company within seven calendar days.

HOW CAN AN EMPLOYER MANAGE A WORKERS' COMPENSATION CLAIM?

- Employers are encouraged to work closely with their Workers' Compensation claims adjusters to ensure active management is occurring in regards to medical care of your employees. A continual review of the management of your employees' claims will assist an employer in reducing their workers' compensation MOD rates and workers' compensation reserve requirements.

WHAT HAPPENS IF THE EMPLOYEE DOES NOT TURN IN THE EMPLOYEE CLAIM FORM?

- If the employee fails to turn in the claim form, they will still be entitled to Workers' Compensation benefits including medical care and disability payments.
- The employer should still report all known information to their Workers' Compensation insurance company within 24 hours of the incident/injury.

WHERE DOES THE EMPLOYEE RECEIVE MEDICAL TREATMENT?

- In case of serious life threatening injury or illness, the employee should be transported to the nearest emergency medical facility.
- In case of an ambulatory, non-life threatening injury or illness, the employee should be directed to the nearest employer designated medical facility unless the employee has pre-designated their own medical provider.

CAN AN EMPLOYEE CHANGE MEDICAL PROVIDERS?

- During the first 30 days of employer-controlled medical care, the employee is allowed to request a change of physician at which time the Workers' Compensation insurance company will provide a list of different medical providers to choose from.
- After the first 30 days, the employee may change to the treating physician of their choice so long as the physician meets the Workers' Compensation law requirements.

WHEN CAN THE EMPLOYEE RETURN TO WORK?

- After a visit to the doctor, the employee should receive a work status form from the doctor indicating what restrictions, if any, are placed on the employee.
- If the work status form is unclear, the designated company representative will contact the Workers' Compensation insurance company for clarification. The employee is not allowed to return to work until clarification is received.
- The designated company representative will only allow the employee to return to work after receipt of medical information that indicates the employee is able to do the work or the employer can accommodate the restrictions. No employees are allowed to return without a medical release.

CAN AN EMPLOYEE WORK LIGHT DUTY?

- The treating doctor should provide a detailed description of work restrictions and limitations as well as the duration of the restrictions after every medical appointment. It is then up to the employer to evaluate if they can provide accommodation for the disability.

- The "light duty" job must meet the physical restrictions placed by the doctor, not violate any union agreement and must not be demeaning or degrading.
- If the employee cannot work a full day or week, Workers' Compensation disability benefits may be provided.
- If the employee refuses to return to work to the light duty job, Workers' Compensation disability benefits will not be provided.

WHAT HAPPENS IF THERE IS A QUESTION WHETHER THE INJURY IS JOB RELATED?

- If the Workers' Compensation insurance company needs further information or questions the injury, they may delay the claim to review it further. Benefits will not be provided on delayed claims.
- The Workers' Compensation insurance company has up to 90 calendar days from the date the employer was notified of a work-related injury or illness to complete the investigation and issue a letter to the employee accepting or denying the claim.
- If the claim is denied, the employee may appeal the decision to the State of California Workers' Compensation Appeals Board.

WHAT CAN I DO IF I THINK THIS IS A FRAUDULENT CLAIM?

- The designated company representative will contact the Workers' Compensation insurance company directly to provide the necessary information in regards to possible fraud. An investigation will be conducted immediately upon notification.
- If the employer suspects abuse by the injured employee on an accepted claim, the designated company representative will contact the Workers' Compensation insurance company to provide necessary details to initiate an investigation. During an investigation, surveillance and/or investigative methods may be used.

WHAT DOES PERMANENT AND STATIONARY MEAN?

- When the treating doctor feels that the condition of the injured employee has reached the point where they will not get any better or any worse, they will deem the injured employee as "permanent and stationary". This determination allows the claim to be evaluated for permanent disability purposes.
- The permanent and stationary determination may be applied at any time. Often, an employee has been back to work in their regular job when the determination is made.
- A Workers' Compensation claim cannot be finally resolved until this determination is made.

CAN AN EMPLOYEE OUT ON DISABILITY BE TERMINATED?

- The decision when, and if, to terminate the employment a disabled employee must be carefully considered and only after consulting with the designated company representative. The employer must take into consideration California's Workers' Compensation laws, human resource policies, union agreements, Americans with Disabilities Act, California's Fair Employment and Housing Act, and any relevant state and federal laws and regulations before any decision is made.

WHAT HAPPENS IF AN EMPLOYEE GETS AN ATTORNEY?

- Once an employee retains an attorney to represent them in their Workers' Compensation claim, the Workers' Compensation insurance company cannot contact the injured worker.
- The employer is allowed to have conversations with the employee but they cannot discuss any issue in dispute nor harass the injured employee.
- If the injured employee's attorney does contact you, please refer them to the designated company representative.

WHEN DOES A WORKERS' COMPENSATION CLAIM CLOSE?

There are four ways a claim involving lost time may be closed:

- The injury/illness has resolved with no permanent disability and no further medical care.
- The claim is settled by Stipulation and all benefits have been paid.
- A Workers' Compensation Appeals Board judge has rendered a determination and all benefits have been paid.
- The parties agree to a Compromise and Release settlement and the Workers' Compensation Appeals Board approves it.

FRAUD AND ABUSE

Under California state law, it is a felony to make or cause to be made a knowingly false or fraudulent material statement or material representation to obtain or deny any compensation, or present or cause to be presented a knowingly false or fraudulent material statement in support of, or in opposition to, any claim for compensation to obtain or deny any compensation. It is a crime to knowingly assist, abet, conspire with, or solicit any person in an unlawful act of workers' compensation insurance fraud.

It is also a crime to make or cause to be made a knowingly false or fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim. Workers' compensation fraud may be punished by imprisonment in county jail for over one year, or in a state prison, for two to five years. A fine may also be imposed not exceeding \$150,000, or double the amount of the fraud, whichever is greater.

If someone is convicted of workers' compensation fraud, the court is required to order restitution, including restitution for any medical evaluation or treatment services obtained or provided. A person convicted of workers' compensation fraud may be charged the costs of the investigation and shall be ineligible to receive or retain any compensation, where that compensation was owed or received as a result of workers' compensation fraud.

HOW TO REDUCE OR PREVENT WORKPLACE FRAUD

The dictionary definition of fraud is the "intentional perversion of the truth in order to induce another to part with something of value." It is an act of deceiving or misrepresenting. When referring to insurance fraud, it refers to people who attempt to gain by claiming dollars through fraudulent means. Usually, this is done by making a claim when one would not ordinarily exist such as in workers' compensation when an individual having an at-home injury claims the injury occurred at work.

Workers' compensation fraud is a growing problem. The National Insurance Crime Bureau (NICB), which investigates and tracks insurance fraud nationally, estimates that workers' compensation fraud costs \$7.2 billion dollars annually. One of every 10 dollars spent for insurance premiums to cover the real injuries suffered in the workplace is estimated as lost due to fraud. The cost of workers' compensation insurance is a significant expense for businesses. In addition to higher insurance premiums, there are other consequences of insurance fraud for businesses, such as: increase in medical costs, production delays as trained employees are at home rather than being productive, increase in training costs, morale issues could develop with employees that continue to work, the affordability of insurance is threatened, and businesses lose their competitive advantage and business as they are forced to raise their prices.

The most common type of workers' compensation fraud is the faked workplace injury. This may be in the form of a totally phony injury, a real injury suffered off the job, or a real injury whose extent is prolonged to avoid returning to work.

By following a few common sense steps, you can reduce or prevent the filing of fraudulent workers' compensation claims. Among these steps are:

1. Examine an employment candidate's work history, background, and references carefully. Look for, question, and verify gaps in employment. Information going back 5 years can be used to apportion costs of a claim for cumulative trauma. You would report this to the claim adjustor and request investigation and apportionment. Note: employees should not ask applicants about any worker's compensation injuries.
2. Communicate your workers' compensation policies and educate your employees about the cost and impact of workers' compensation insurance. Employees need to understand the employer, not the insurance company, ultimately pays for the costs of injuries.
3. Report all incidents, however minor. Sometimes employees do not think they are hurt at first, but may notice the symptoms later.
4. Take complaints about working conditions seriously, and do what you can to address them. Disgruntled employees are a major source of workers' compensation fraud.
5. Forward any information you have or anything you learn to the claims adjustor.
6. Participate in periodic reviews of the workplace injuries.
7. Correct safety problems immediately. The safer the workplace, the less chance of injury. Make sure known hazards are taken care of immediately to prevent any work accidents or injuries.
8. Make safety a top priority and complete a thorough investigation.
9. Stay in touch with your employee who is out on a leave of absence due to a work-related injury/illness. This keeps the rapport going with the employee so he or she will want to return to work. It also provides a check to ensure the employee is in fact at home when he or she should be.
10. Maintain good morale: treat all workers with respect.

If you suspect there is fraud or abuse, please make sure this information is shared with the designated company representative.

CAL-OSHA RECORDING REQUIREMENTS

RECORDING WORK-RELATED INJURIES AND ILLNESSES

Employers in California need to be aware Cal-OSHA has the requirement for employers to report and record work-related injuries and illnesses. The reporting and recording processes are separate. Some employers need not always perform both processes.*

Employers must only record injuries or illnesses if they are work-related. Work-related injuries and illnesses can include incidents away from the workplace if the employee was elsewhere because of a work-related activity or while engaged in a work-related activity arising out of or in the course of business.

Injuries that occur while commuting to and from work are excluded. However, an injury that occurs while an employee is traveling on company business is considered work-related, unless the employee is engaged in purely personal activities.

WHICH WORK-RELATED INJURIES AND ILLNESSES SHOULD YOU RECORD?

Employers should record work-related injuries and illnesses that result in:

- Medical treatment beyond first aid
- Restricted work activity or job transfer, or
- Days away from work
- Loss of consciousness
- Death

REQUIRED RECORDS

The following records are required to be completed by employers not exempt from recording:

- Injury and Illness Incident Report – Form 301
- Work Related Injuries and Illness Log – Form 300
- Work Related Injuries and Illness Summary – Form 300A
- OSHA Log 300

* Employers with fewer than 10 employees or whose organization is classified in a specific, low hazard North American Industry Classification System (NAICS) category are exempt from these requirements. For a listing, go to: <https://www.dir.ca.gov/dosh/etools/recordkeeping/CASstandard/CA143002.htm>.

RECORDING THE INCIDENT

When a work-related injury or illness occurs, the following steps need to occur:

1. Record the incident on the Injury and Illness Incident Report - Form 301:
 - Record the incident within seven calendar days of being notified.
 - Separate records must be kept for each establishment.
 - Attribute the incident to the location where it occurred, even if the employee normally works at another location.
 - At the employee's request, the employee's name can be omitted and instead you can insert the phrase "privacy case" if the injury or illness involves
 - an intimate body part or to the reproductive system
 - an incidence of sexual assault
 - mental illness
 - infection with HIV, hepatitis, or tuberculosis
 - a needle stick injury or cut from a sharp object that is contaminated with blood or other potentially infectious material
 - any other injuries or illnesses if the employee independently and voluntarily requests their name not be entered on the log.

Keep a separate log that identifies the employee by case number. You can use discretion when describing the nature of the injury. You must be able to produce this log, also known as a privacy case list, upon request by Cal/OSHA.

2. Record a case number on the *Injury and Illness Incident Report - Form 301*.
3. Transfer the information from the *Injury and Illness Incident Report - Form 301* to the *Work-Related Injuries and Illnesses Log - Form 300*.
4. Update the *Form 301* and *Form 300* as the nature of the injury or illness and its consequences become known.

Attached in Appendix C are the OSHA Form 300 Instructions with detailed information as to what needs to be recorded on each required form and/or log.

CAL-OSHA REPORTING REQUIREMENTS

REPORTING SERIOUS INJURY OR DEATH

All employers, regardless of size, must immediately report to Cal-OSHA all incidents that result in any of the following:

- Death of an employee
- Hospitalization of an employee for more than 24 hours for treatment other than observation
- Loss or serious disfigurement of a body part

You must immediately report a serious injury or death by telephone or email to the nearest Cal-OSHA District Office. “Immediately” is defined as soon as practically possible, but no longer than eight (8) hours after you know or should have known about the incident. If you can demonstrate that there were problematic circumstances, you can make the report no more than 24 hours after the incident. In addition to making the phone call or sending the email, it is advisable to fax a copy of the report to the Cal-OSHA District Office. Keep a copy that includes the date, time and fax number to which it was sent.

You must submit the incident reports in two situations:

- When an employee is seriously or fatally injured
- When you receive an annual survey form from the Bureau of Labor Statistics or a specific request from Cal-OSHA

California law mandates a fine of \$5,000 for employers who do not report a serious injury or death. Individual employees may be liable for up to one year in jail and/or a \$15,000 fine. Corporations face fines up to \$150,000.

REPORTABLE INCIDENT PROCEDURES

When a reportable incident occurs:

1. Prepare an incident report – Form 301, which includes all of the following information:
 - Incident time and date
 - Your name, address and telephone number
 - Name and job title or badge number of the person reporting the accident
 - Address of the incident site
 - Name of the person to contact at the incident site
 - For each injured employee:
 - Name and address
 - Nature of the injury

- Location to which the injured employee was moved
 - Identity of other law enforcement agencies and personnel present
 - A description of the incident
 - If the incident scene or equipment that caused the incident was altered
2. Submit this report to Cal-OSHA no later than eight hours after the incident occurs or eight hours after a death occurs, regardless of the time elapsed between the incident and the death.

PREPARING THE ANNUAL SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES

If required, you must prepare and post a *Summary of Work-Related Injuries and Illnesses - Form 300A* from February 1 to April 30 of the year following the year covered by the form. The *Form 300A* summarizes the work-related injuries and illnesses that occurred at your organization during a calendar year.

Form 300A must reflect the nature and consequences of events during the year as accurately as possible. The annual summary must be completed even if no work-related injuries or illnesses occurred during the year. If none occurred, simply enter “0.”

For each establishment:

1. Prepare a separate *Summary of Work-Related Injuries and Illnesses - Form 300A*.
2. Make sure the annual summary is certified by one of the following people:
 - An owner
 - A corporate officer
 - The highest ranking person at the establishment
 - The immediate supervisor of the highest ranking person at the establishment
3. From February 1 to April 30 of the year following the one to which the *Form 300A* applies, post the *Form 300A* in a conspicuous place where you normally post employee posters. The *Form 300A* cannot be altered, defaced or covered by other material. If you have employees on the payroll during the posting period, but they do not report at least weekly to the posting location, you must give or mail a copy of the *Form 300A* to them.

MAINTAINING YOUR WORK-RELATED INJURY AND ILLNESS RECORDS

You must keep the following records for five (5) years after the end of the year that the records cover:

- *Work-Related Injuries and Illnesses Log - Form 300*
- The privacy case list, if one was created for that year
- *Injury and Illness Incident Report - Form 301*
- *Summary of Work-Related Injuries and Illnesses - Form 300A*

During this five-year period, you must update the *Form 300* to include any newly discovered recordable injuries or illnesses. You must also show any changes in classification for previously recorded events. You are not required to update *Work-Related Injuries and Illnesses Summary - Form 300A* or the individual *Injury and Illness Incident Report - Form 301* reports.

If you sell your business, you are responsible only for the period during which you owned the business. You must transfer all records to the new owner. The new owner must save the records.

ACCESSING WORK-RELATED INJURY AND ILLNESS RECORDS

Employees, former employees and their properly authorized personal representatives are entitled to a copy of all of the following:

- The individual's incident report(s) – *Form 301*
- *Work-Related Injuries and Illnesses Log - Form 300*, with names of employees deleted for privacy cases
- Current or archived annual summaries – *Form 300A*

You must provide these copies by the end of the next business day after the request.

An authorized employee representative, such as a collective bargaining agent, is entitled to a copy of the *Work-Related Injuries and Illnesses Log - Form 300* for the establishment it represents. You must provide the copy to the requesting party within seven calendar days of the request. You must remove the following information from the delivered copy:

- Name
- Address
- Date of birth
- Date of hire
- Sex
- Physician's name
- Treatment location
- If treated in an emergency room
- If hospitalized overnight

Before disclosing *Work-Related Injuries and Illnesses Log - Form 300* or *Injury and Illness Incident Report - Form 301* reports in response to any other request, you must delete all personal identifying information unless you provide the information for the following purposes:

- To a consultant you hire to evaluate your safety and health program
- To process workers' compensation or other insurance benefits
- To public health or law enforcement agencies, except where notification and opportunity to object under Health Insurance Portability and Accountability Act (HIPAA) privacy standards apply

APPENDIX A

PRE-DESIGNATION OF PERSONAL PHYSICIAN

[HTTPS://WWW.EMPLOYERS.ORG/CLIENTUPLOADS/HR_FORMS/DWCFOM_9783_PREDESIGNATION_FORM.PDF](https://www.employers.org/clientuploads/hr_forms/dwcfom_9783_predesignation_form.pdf)

REPORT OF INJURY FORM

[HTTPS://WWW.EMPLOYERS.ORG/CLIENTUPLOADS/HR_RESOURCES/REPORT_OF_INJURY_FORM.PDF](https://www.employers.org/clientuploads/hr_resources/report_of_injury_form.pdf)

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS (DWC-1 FORM)

[HTTP://WWW.DIR.CA.GOV/DWC/DWCFOM1.PDF](http://www.dir.ca.gov/dwc/dwcfom1.pdf)

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS, FORM 5020

[HTTPS://WWW.DIR.CA.GOV/DOSH/DOSHREG/FORM5020.PDF](https://www.dir.ca.gov/dosh/doshreg/form5020.pdf)

PRE-DESIGNATION OF PERSONAL PHYSICIAN

PREDESIGNATION OF PERSONAL PHYSICIAN

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

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

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

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

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

(name of doctor)(M.D., D.O., or medical group) _____ (street address, city, state, ZIP)
_____ (telephone number)

Employee Name (please print): _____

Employee's Address: _____

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

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation:

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

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

Title 8, California Code of Regulations, section 9783.

DWC FORM 9783 (7/2014)

REPORT OF INJURY FORM

REPORT OF INJURY FORM
(For reporting work-related injuries/illnesses)

The injured worker and supervisor must complete and file this report with the Human Resources WITHIN 24 HOURS of any on-the-job injury.

PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS			
Employee Name (Last Name, First Name):		Employee ID #:	
Home address:		SSN:	
Home phone:	Date of Birth:	Work phone:	
Job Title:	Department Name:		
Date of occurrence:	Time of accident:	Location of injury occurrence:	
How was injury incurred:		Time employee began work:	
Were you ever treated for a similar condition before:		Body part(s) injured:	
If yes, give details:			

Employee's Signature: _____ Date: _____

Part B: SUPERVISOR'S STATEMENT			
Injury:		Payroll Location:	
Name and address of hospital or physician:	Did injured worker receive medical treatment:	Date:	
Object or machinery causing injury:			
Was there contact with any other person's blood or body fluid:			
If yes, name and address of source person:		Did weather conditions contribute to occurrence:	
How could a similar occurrence be avoided:		If yes, what were the weather conditions:	
Describe any unsafe practice:			
Name and phone number of witnesses (if any):			
Did injured worker lose time from work:	If yes, first full day of disability:		
Has the injured worker returned to work:	If yes, date returned:		

IF THE INJURED WORKER RETURNS TO WORK OR BECOMES DISABLED AFTER THIS FORM HAS BEEN FILED, IT IS IMPERATIVE HUMAN RESOURCES BE CALLED IMMEDIATELY.

Supervisor's Name:	Signature:
Phone ext:	Date Completed:

Original and one copy of the Report of Injury Form are needed.

- 1. Original to: Human Resources**
- 2. Copy to be retained for department records.**

Part A is to be completed by the injured worker immediately after he/she has reported any on-the-job injury to his/her supervisor. All questions must be answered. The employee's signature is required.

Part A is to be verified by the Supervisor.

Part B is to be completed and signed by the supervisor. Discuss the occurrence in detail with the injured worker prior to completing this section. If you have any valid reason to believe the occurrence did not happen as described, use the word "Alleged" in your description of injury.

If you have any questions regarding the filing of this form, contact Human Resources.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

FILL THIS FORM OUT COMPLETELY

INVESTIGATOR: _____ **DATE OF REPORT:** _____

Name(s) of Injured: _____ **Home Phone:** _____

_____ **Work Phone:** _____

Department: _____ **Job Title:** _____

Date of Accident: _____ **Time:** _____

Address where accident occurred: _____

Exact location of accident: _____

What is the nature of the injury/illness: _____

First aid administered: _____

Medical treatment: _____

Doctor/Clinic/Hospital Name & Phone: _____

What was the employee doing just before the accident happened: _____

Describe how accident happened: _____

What Caused the accident: _____

What object or substance directly harmed the employee? _____

Corrective actions taken: _____

Was person able to return to work after accident? _____

Other persons involved: _____ **Witnesses:** _____

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS (DWC-1 FORM)

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



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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACION 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) 736-7481. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

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 División de Compensación al Trabajador al (800) 736-7481 para oír información grabada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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

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

<p>Employee—complete this section and see note above</p> <p>1. Name. <i>Nombre</i> _____ Today's Date. <i>Fecha de Hoy</i> _____</p> <p>2. Home Address. <i>Dirección Residencial</i> _____</p> <p>3. City. <i>Ciudad</i> _____ State. <i>Estado</i> _____ Zip. <i>Código Postal</i> _____</p> <p>4. Date of Injury. <i>Fecha de la lesión (accidente)</i> _____ Time of Injury. <i>Hora en que ocurrió</i> _____ a.m. _____ p.m.</p> <p>5. Address and description of where injury happened. <i>Dirección/lugar donde ocurrió el accidente</i> _____</p> <p>6. Describe injury and part of body affected. <i>Describe la lesión y parte del cuerpo afectada</i> _____</p> <p>7. Social Security Number. <i>Número de Seguro Social del Empleado</i> _____</p> <p>8. <input type="checkbox"/> Check if you agree to receive notices about your claim by email only. <input type="checkbox"/> Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico. <i>Employee's e-mail</i> _____ <i>Correo electrónico del empleado</i> _____</p> <p><small>You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. Usted recibirá notificaciones de beneficios por correo ordinario si usted no elige, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.</small></p> <p>9. Signature of employee. <i>Firma del empleado</i> _____</p>	<p>Empleado—complete esta sección y note la nota arriba</p> <p>1. Nombre _____ Hoy's Date. <i>Fecha de Hoy</i> _____</p> <p>2. Dirección Residencial _____</p> <p>3. Ciudad _____ Estado _____ Zip. <i>Código Postal</i> _____</p> <p>4. Fecha de la lesión. <i>Fecha de la lesión (accidente)</i> _____ Hora en que ocurrió _____ a.m. _____ p.m.</p> <p>5. Dirección/lugar donde ocurrió el accidente _____</p> <p>6. Describe la lesión y parte del cuerpo afectada _____</p> <p>7. Número de Seguro Social del Empleado _____</p> <p>8. <input type="checkbox"/> Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico. <i>Employee's e-mail</i> _____ <i>Correo electrónico del empleado</i> _____</p> <p><small>Usted recibirá notificaciones de beneficios por correo ordinario si usted no elige, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.</small></p> <p>9. Firma del empleado _____</p>
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<p>Employer—complete this section and see note below</p> <p>10. Name of employer. <i>Nombre del empleador</i> _____</p> <p>11. Address. <i>Dirección</i> _____</p> <p>12. Date employer first knew of injury. <i>Fecha en que el empleador supo por primera vez de la lesión o accidente</i> _____</p> <p>13. Date claim form was provided to employee. <i>Fecha en que se le entregó al empleado la petición</i> _____</p> <p>14. Date employer received claim form. <i>Fecha en que el empleado devolvió la petición al empleador</i> _____</p> <p>15. Name and address of insurance carrier or adjusting agency. <i>Nombre y dirección de la compañía de seguros o agencia administradora de seguros</i> _____</p> <p>16. Insurance Policy Number. <i>El número de la póliza de Seguro</i> _____</p> <p>17. Signature of employer representative. <i>Firma del representante del empleador</i> _____</p> <p>18. Title. <i>Título</i> _____ 19. Telephone. <i>Teléfono</i> _____</p>	<p>Empleador—complete esta sección y note la nota abajo</p> <p>10. Nombre del empleador _____</p> <p>11. Dirección _____</p> <p>12. Fecha en que el empleador supo por primera vez de la lesión o accidente _____</p> <p>13. Fecha en que se le entregó al empleado la petición _____</p> <p>14. Fecha en que el empleado devolvió la petición al empleador _____</p> <p>15. Nombre y dirección de la compañía de seguros o agencia administradora de seguros _____</p> <p>16. El número de la póliza de Seguro _____</p> <p>17. Firma del representante del empleador _____</p> <p>18. Título _____ 19. Teléfono _____</p>
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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.

Empleador: Se requiere que Ud. feche esta forma y que proporcione 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.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

Rev. 1/1/2016

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS, FORM 5020

TITLE OF CURRENT EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in legible type if possible two copies to:		OSHA CASE NO.	
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.		California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.			
EMPLOYER	1. FIRM NAME		1a. Policy Number		Please do not use this column
	2. MAILING ADDRESS (Number, Street, City, Zip)		2a. Phone Number		CASE NUMBER
CITY	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)		3a. Location Code		OWNERSHIP
	4. NATURE OF BUSINESS, e.g., Painting contractor, wholesale grocer, school, hotel, etc.		3. State unemployment insurance and/or		INDUSTRY
STATE	5. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Inland Empire <input type="checkbox"/> Other Gov't, Specify _____		6. If EMPLOYEE'S DATE OF BIRTH (month/year)		OCCUPATION
	7. DATE OF INJURY/ONSET OF ILLNESS (month/year)		8. TIME EMPLOYEE BEGAN WORK (month/year)		SEX
COUNTY	9. TIME INJURY/ILLNESS OCCURRED (month/year)		10. DATE EMPLOYEE WAS PROVIDED NOTICE OF CLAIM FORM (month/year)		AGE
	11. DATE OF EMPLOYEE'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (month/year)		12. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (month/year)		DAILY HOURS
ZIP	13. 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		14. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAYS PER WEEK
	15. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		16. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.		WEEKLY HOURS
DEPARTMENT	17. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, flame burner, coalbin		17a. Other Workers injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		WEEKLY WAGE
	18. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.		19. HOW INJURY/ILLNESS OCCURRED: DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and stepped on loose material. As he fell, he brushed against beam work, and burned right hand. USE SEPARATE SHEET IF NECESSARY.		COUNTY
NATURE OF INJURY	20. Name and address of physician (number, street, city, zip)		20a. Phone Number		PART OF BODY
	21. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes then, name and address of hospital (number, street, city, zip)		21a. Phone Number		SOURCE
EVENT	22. EMPLOYEE NAME		22a. SOCIAL SECURITY NUMBER		EVENT
	23. DATE OF BIRTH (month/year)		23a. PHONE NUMBER		SECONDARY SOURCE
EXTENT OF INJURY	24. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		24a. EMPLOYMENT STATUS: <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		EXTENT OF INJURY
	25. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		25a. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?		DATE (mm/dd/yy)
26. GROSS WAGE/SALARY \$ _____ per _____		26. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours.		26b. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, credits, bonuses, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> 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 14300.25), to others for the purpose of processing a workers' compensation or other insurance claim, and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.					

FORM 5020 (Rev. 7/1) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

APPENDIX B

RETURN TO WORK POLICY (SAMPLE)

We are committed to returning injured employees to temporarily modified or alternative work as soon as possible. This will be done by assigning modified or alternative duty to employees who are temporarily disabled from their regular job as the result of a work-related injury or illness. All such modified or alternative work assignments shall be within the specific limitations and restrictions as described by the treating physician. This policy is intended to maximize employee productivity and provide therapeutic work or assignments consistent with the employee's capabilities during the recuperation period, and prior to returning to full duty. The Company is committed to providing our employees with an opportunity to continue as valuable members of our company team while recovering from a work-related injury.

1. Medical clearance to perform the modified or alternative duty must be provided from the treating physician. It must be in writing, and must identify the employee's limitations and restrictions in sufficient detail to enable the company to determine a suitable work assignment.
2. Modified duty or alternative work assignments will normally be within the employee's department. If no suitable temporary work assignment is available within the employee's department, the designated company representative will coordinate with the employee's department to pursue other alternatives.
3. Where feasible, the designated company representative will coordinate and effect a temporary assignment of the employee on an inter-department basis.
4. An employee assigned to modified or alternative work tasks will be paid at least 85 percent of their wages and benefits during the assignment as paid in the employee's regular position.
5. An employee will be returned to full, unrestricted work duties, at his or her regular position, upon receipt of a written release from the treating physician.

JOB PLACEMENT

Placing an employee into a modified or alternative work assignment(s) must be approved by the employee's regular department and the designated company representative. Approvals will be based on the employee's ability to perform the duties of the assignment(s), within the restrictions imposed by the treating or evaluating physician, without aggravating the existing injury or illness.

The job must meet the work restrictions in the doctor's report. The offer could involve:

- **Regular work:** An employee's old job, for a period of at least 12 months, paying the same wages and benefits as paid at the time of an injury and located within a reasonable commuting distance of where your employee lived at the time of the injury.
- **Modified work:** An employee's old job, with some changes that allows them to do it. If your employee's doctor says the employee will not be able to return to the job they had at the time of injury, you are encouraged to offer modified work instead of supplemental job displacement benefits (SJDB). The alternative work must meet the employee's work restrictions, last at least 12 months, pay at least 85 percent of the wages and benefits the employee was paid at the time of injury, and be within a reasonable commuting distance of where the employee lived at the time of injury.
- **Alternative work:** A new position. If the employee's doctor says they will not be able to return to the job held at the time of injury, you are encouraged to offer the employee alternative work instead of SJDB. The alternative work must meet the employee's work restrictions, last at least 12 months, pay at least 85 percent of the wages and benefits the employee was paid at the time of injury, and be within a reasonable commuting distance of where the employee lived at the time of injury.

If you offer an employee modified or alternative work, the employee may have only 30 days to accept the offer. If the employee doesn't respond within 30 days, you may withdraw the offer.

If an employee fails to respond to the offer of modified or alternative work within 30 days or rejects the job offer, the employee may not be entitled to supplemental job displacement benefits.

RESPONSIBILITIES

SUPERVISORS/MANAGERS

As a manager or supervisor, you have a major role in the success of this program.

1. Notify the designated company representative immediately upon notification of any medical preclusions or restrictions placed upon an employee by a physician to perform their usual and customary work as a result of a work-related injury or illness.
2. Assist and coordinate with the designated company representative to develop and propose alternative or modified work assignments.
3. Ensure that the injured employee receives the necessary assistance from co-workers and the employee does not exceed the restrictions as indicated by the physician.

4. Forward all medical documentation to the designated company representative for continued verification of disability.
5. If the injured employee is working on a modified or alternative work assignment in another department, the alternative department's management is responsible for maintaining the time card and scheduling hours for the injured employee.
6. Continual monitoring for appropriate accommodation & risk of re-injury, as well as fitness for transitioning toward full-duty work.
7. If your department has other alternative work functions or tasks an injured worker can perform, please provide this information to the designated company representative. Upon receipt, the designated company representative will contact you to coordinate placement.

EMPLOYEES

1. Employees are expected to return to work the same day following their visit with the treating physician.
2. Employees are expected to communicate to their immediate supervisor and the designated company representative any work restrictions or accommodations requested by the treating physician as soon as possible.
3. Employees should perform only those duties assigned.
4. Employee should notify their supervisor of any difficulty in performing the duties assigned.
5. Employee must provide advance notice to their immediate supervisor of scheduled medical physician's and physical therapy appointments.
6. Employee is expected to perform all duties required so long as the work restrictions are being met. Should the workers' performance appraisal need to be completed while the worker is in the modified or alternative work assignment, a collaborative effort between the employee's regular department and assigned alternative department should be under taken to complete a timely appraisal.

THE DESIGNATED COMPANY REPRESENTATIVE

1. Maintain open lines of communication with the injured employee throughout the period of disability or modified duty.
2. Coordinate with the departments and the Workers' Compensation insurance carrier for the purpose of obtaining a written release for the employee's proposed, modified or alternative work assignments.
3. Monitor modified or alternative work assignments.
4. Assign alternate work assignments when modified or alternative work is not available in the employee's regular department.

5. If applicable, inform the injured employee's regular department and assigned alternative department of the current work status of the injured employee.

APPENDIX C

Injury and Illness Incident Report – Form 301

Work-Related Injuries and Illnesses Log – Form 300

Summary of Work-Related Injuries and Illnesses – Form 300A

All are available at: <https://www.osha.gov/recordkeeping/new-osh300form1-1-04-FormsOnly.pdf>

OSHA's Form 301 Injury and Illness Incident Report

Instructions: 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 when the information is being used for occupational safety and health purposes.



Form 301a-1200 (01/15/12)

This injury and illness incident report is one of the first forms you must fill out when a work-related injury or illness has occurred. Together with the Log of Work-Related Injuries and Illnesses and the accompanying Summary, these forms help the employer and OSHA determine the nature and severity of work-related incidents.

Within 7 calendar days after you receive information that a work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other programs may be acceptable alternatives. To be considered a questionnaire form, any alternative must contain all the information asked for on this form.

According to Public Law 91-360 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 3 years following the year in which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____ Date _____

Title _____

Phone _____

Information about the employee

1) Name _____

2) Sex _____

City _____ State _____ ZIP _____

3) Job title _____

4) Job level _____

5) Full-time
 Part-time

Information about the physician or other health care professional

6) Name of physician or other health care professional _____

7) If a nurse or other non-physician, describe the professional _____

8) Title _____

9) Sex _____

City _____ State _____ ZIP _____

10) Name of hospital or other facility where hospitalized _____

11) Was the patient hospitalized or hospitalized _____

Yes
 No

Information about the case

12) Date of incident _____ (Month is as written in the log of injuries and illness)

13) Time of day _____ (AM/PM)

14) What was the employee doing just before the incident occurred? Describe the activity as well as the work, equipment, or material the employee was using. Be specific. Examples: "loading a truck while carrying roofing material"; "pouring concrete for a road spacer"; "drill computer keyboard"

15) What happened? Tell us how the injury occurred. Be specific. "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when pipe broke during experiment"; "Worker developed contact dermatitis over time."

16) What was the injury or illness? Tell us the part of the body that was affected and how it was affected. Be as specific as possible. "Back"; "ankle"; "ear"; "fingers"; "stomach pain"; "chemical burn, hand"; "cut and bruise of forehead."

17) What object or substance directly caused the employee's injury? "Concrete floor"; "Welder"; "Scaffolding"; "etc." If the question does not apply to the incident, then it should be blank.

18) Did the employee think, when the incident occurred, that it could be prevented? _____

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including reviewing instructions, searching existing data sources, gathering and maintaining the data needed, reviewing and editing the collection of information, and reviewing and completing the review of the collection of information by the Department of Labor, OSHA. Office of Occupational Safety and Health, Bureau of Safety and Health Enforcement, OSHA-301 (2012). Do not send this completed form to OSHA.

DISCLAIMER

The CEA Step by Step Guide to Workers' Compensation for California Employers is not intended as, nor is it a substitute for, legal advice, and any employer contemplating adopting a new policy, changing an existing policy, or with employees located in states outside of California, should feel free to consult with its own legal counsel.



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