
# Injury & Illness Prevention Program

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## Responsibility

The college president and/or designee is the IIPP administrator and has the authority and responsibility for implementing and maintaining this IIPP for Crafton Hills College.

Managers and supervisors are responsible for implementing and maintaining the IIPP in their work areas and for answering questions about the IIPP. A copy of this IIPP is available from each manager and supervisor.

## Compliance

All workers, including managers and supervisors, are responsible for complying with safe and healthful work practices. Our system of ensuring that all workers comply with these practices includes the following:

- Informing workers of the provisions of our IIPP
- Disciplining workers for failure to comply with safe and healthful work practices.

## Communication

All managers and supervisors are responsible for communicating with all workers about occupational safety and health in a form readily understandable by all workers. All workers are required to report occupational injuries and illnesses to their supervisor immediately. Workers will complete the employee statement of occupational injury or illness form and the worker's compensation claim form (DWC-1). Our communication system encourages all workers to inform their managers and supervisors about workplace hazards without fear of reprisal. Our communication system includes:

- Direct one-on-one communication
- Training programs
- Posted or distributed safety information

## Hazard Assessment

Periodic inspections to identify and evaluate workplace hazards shall be performed by college managers/supervisors.

Periodic inspections are performed according to the following schedule:

- When we initially establish our IIPP
- When new substances, processes, procedures or equipment which present potential new hazards are introduced into our workplace
- When new, previously unidentified hazards are recognized
- When occupational injuries and illness occur; and
- Whenever workplace conditions warrant an inspection
- When permanent or part-time workers are hired or re-assigned to processes, operations or tasks for which a hazard evaluation has not been previously conducted.

College managers and supervisors shall conduct periodic safety inspections of their facilities, equipment and projects to identify unsafe conditions and work practices. Records of these inspections and actions taken to correct any identified unsafe conditions shall be maintained by the appropriate manager or supervisor.

The college managers and supervisors will provide a report of observed violations that require correction to the appropriate department(s). The college manager or supervisor of the inspected unit is responsible for making and documenting the corrections to the listed violations.

## Accident/Exposure Investigations

When occupational injuries and illness occur, college managers and supervisors shall conduct safety inspections of their facilities, equipment and projects and interview injured workers and witnesses to identify unsafe conditions and work practices. Records of these inspections and actions taken to correct any identified unsafe conditions shall be maintained by the appropriate manager or supervisor.

The college managers and supervisors will complete the supervisor statement of occupational injury or illness and the witness statement of employee injury forms and report observed violations that require correction to the appropriate department(s) and administrator(s).

The college manager or supervisor of the inspected unit is responsible for making and documenting the corrections to the listed violations.

## Hazard Correction

Unsafe or unhealthy work conditions, practices or procedures shall be corrected in a timely manner.

If the unsafe condition can not be immediately abated, a suitable timetable for correcting the unsafe condition based on the severity of the hazard shall be established by the appropriate college administrator(s).

If a hazard presents an imminent danger to employees or building occupants and the hazard cannot be immediately corrected without endangering personnel and/or property, then all exposed personnel will be evacuated from the area. Employees remaining to correct the identified hazardous condition may do so only if they are properly trained.

## Training and Instruction

All workers, including managers and supervisors, shall have training and instruction on general and job-specific and health practices. Employees attending or receiving training mandated by this program will sign attendance sheets and actively participate in training.

Training will be provided when:

- The IIPP is first established and when modifications and revisions are completed.
- Prior to assignment
- Potentially exposed to new hazards
- Assigned to new work tasks

- New chemicals, materials, equipment or processes are introduced into the workplace
- Workers safety performance is deficient

What training is provided:

- Explanation of the employer's IIPP, Emergency Action and Fire Prevention Plan and measures for reporting unsafe conditions, work practices, injuries and when additional instruction is needed.
- Potential hazards in their workplace and those specifically related to their job assignment.
- The means of minimizing potential hazards, including work conditions, safe work practices and personal protective equipment.
- Provisions for medical services and first aid including emergency procedures.

Documentation of training:

- Safety training records shall be established for each employee and maintained in their respective work area by the appropriate college manager/supervisor.

## Recordkeeping

All records and reports that are generated by this program shall be maintained by the appropriate college manager/supervisor.

## HAZARD ASSESSMENT AND CORRECTION RECORD

**Date of Inspection:** **Person Conducting Inspection:**

**Unsafe Condition or Work Practice:**

**Corrective Action Taken:**

San Bernardino Community College District

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

# INSTRUCTIONS FOR INJURED WORKER

**IF YOU ARE INJURED AT WORK:**

REPORT THE INJURY TO YOUR SUPERVISOR IMMEDIATELY. YOUR SUPERVISOR WILL COMPLETE THE SUPERVISOR REPORT OF INJURY. THE SUPERVISOR WILL ALSO GIVE YOU THE FOLLOWING FORMS TO COMPLETE:

- *EMPLOYEE REPORT OF INDUSTRIAL ACCIDENT*
- *DWC-1 CLAIM FORM*
- *EMPLOYEE NOTIFICATION OF RIGHTS MATERIAL (MPN)*
- *AUTHORIZATION FOR MEDICAL TREATMENT*

**IF YOU NEED TO SEE A DOCTOR:**

YOUR SUPERVISOR WILL GIVE YOU THE COMPLETED *AUTHORIZATION FOR MEDICAL TREATMENT* AND NOTIFY THE HUMAN RESOURCES OFFICE.

**IF YOU DO NOT NEED TO SEE A DOCTOR:**

PLEASE CHECK THE BOX INDICATING THAT "I *DECLINE* MEDICAL TREATMENT…" ON THE *AUTHORIZATION FOR MEDICAL TREATMENT* FORM. IF YOU NEED MEDICAL TREATMENT AT A LATER DATE, PLEASE ASK YOUR SUPERVISOR FOR A NEW *AUTHORIZATION FOR MEDICAL TREATMENT* FORM.

**PLEASE KEEP ALL SCHEDULED APPOINTMENTS:**

IF YOU CANNOT KEEP AN APPOINTMENT, PLEASE CALL KEENAN AT 1-800-654-8347 EXT 1107. MISSED APPOINTMENTS MAY RESULT IN LOSS OF BENEFITS AND YOUR ABILITY TO PARTICIPATE IN THE RETURN TO WORK PROGRAM.

**IF YOU WISH TO CHANGE PHYSICIANS:**

YOU MAY CHANGE PHYSICIANS ONCE YOU HAVE RECEIVED YOUR INITIAL MEDICAL ATTENTION AS LONG AS THE DOCTOR YOU CHOOSE IS WITHIN THE MEDICAL PROVIDER NETWORK (MPN). INFORMATION REGARDING THE MPN WILL BE GIVEN TO YOU AT THE TIME OF YOUR INJURY. IF YOU HAVE QUESTIONS, PLEASE CONTACT KEENAN AT 1-800-654-8347 X1107 OR THE MPN COORDINATOR LISTED ON *THE EMPLOYEE NOTIFICATION OF RIGHTS MATERIAL*.

**KEEP HUMAN RESOURCES AND YOUR SITE INFORMED:**

IT IS YOUR RESPONSIBILITY TO BRING A COPY OF YOUR WORK STATUS TO THE HUMAN RESOURCES OFFICE IMMEDIATELLY FOLLOWING EVERY DOCTOR VISIT. YOU ARE RESPONSIBLE TO PROVIDE YOUR SUPERVISOR WITH A COPY. IF YOU ARE GIVEN WORK RESTRICTIONS BY YOUR PHYSICIAN, THEY SHOULD CLEARLY STATE WHAT YOUR LIMITATIONS ARE, INCLUDING ANY RECOMMENDED CHANGE IN YOUR NORMAL SCHEDULE. BE CERTAIN YOU UNDERSTAND THESE LIMITATIONS AND THEY ARE CLEARLY WRITTEN ON YOUR STATUS REPORT PROVIDED TO THE HUMAN RESOURCES OFFICE.

**RETURN TO WORK PROGRAM:**

THE DISTRICT'S RETURN TO WORK PROGRAM PROVIDES OPPORTUNITIES FOR INJURED EMPLOYEES TO RETURN TO WORK WITH MEDICAL RESTRICTIONS AS OUTLINED BY THE TREATING PHYSICIAN.

AN IMPORTANT PART OF RECOVERING FROM AN INJURY IS RETURNING TO WORK.

THE TEMPORARY MODIFIED DUTIES WILL BE ALLOWED FOR 60 DAYS WITH A PERIODIC REVIEW. THE TEMPORARY MODIFIED DUTIES WILL BE RE-EVALUATED AT THE END OF THOSE 60 DAYS.

TEMPORARY MODIFIDED DUTIES AND/OR CHANGES IN YOUR WORK SCHEDULE REQUIRES APPROVAL. PROCESS IS BELOW:

- PROVIDE HUMAN RESOURCES WITH YOUR TREATING PHYSICIAN'S DOCUMENTATION SPECIFYING YOUR LIMITATIONS
- HR WILL WORK WITH YOUR SUPERVISOR TO EVALUATE THE MODIFIED JOB DUTY ASSIGNMENTS IF APPLICABLE
- A MEETING WILL BE HELD WITH YOU TO DISCUSS YOUR OPTIONS

TEMPORARY MODIFIED DUTIES WILL BE TERMINATED AND THE EMPLOYEE PLACED OFF WORK IF ONE OF THE FOLLOWING OCCURS:

- THE TREATING PHYSICAN WRITES THE EMPLOYEE OFF WORK;
- THE TREATING PHYSICIAN INCREASES MEDICAL RESTRICTIONS THAT CANNOT BE ACCOMODATED
- THE EMPLOYEE DOES NOT FOLLOW ALL THE MEDICAL DIRECTIVES OF HIS/HER TREATING PHYSICIAN

***NOTES:***

1. ***EMPLOYEES ON WORKERS COMPENSATION MAY NOT LEAVE THE STATE OF CALIFORNIA WITHOUT PRIOR APPROVAL FROM THE DISTRICT. ED CODE SECTION #87787, CSEA BARGAINING AGREEMENT SECTION 14.5.6 UNDER INDUSTRIAL ACCIDENT AND ILLNESS LEAVE***
2. ***"WORKERS' COMPENSATION FRAUD IS A FELONY"-ANYONE WHO KNOWINGLY FILES OR ASSISTS IN THE FILING OF A FALSE WORKERS' COMPENSATION CLAIM MAY BE FINED UP TO $50,000 AND SENT TO PRISON FOR UP TO FIVE YEARS (INSURANCE CODE SECTION 1871.4)***

**IF YOU HAVE ANY QUESTIONS, CONTACT HUMAN RESOURCES AT 909-382-4040**

SAN BERNARDINO COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

# EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

***EMPLOYEE PERSONAL INFORMATION***

EMPLOYEE NAME: _____ EMPLOYMENT SITE: _____

HOME ADDRESS: _____ PHONE NUMBER: _____

_____ DATE OF BIRTH: _____

_____ SOCIAL SECURITY #: _____

*PLEASE CHECK ALL THAT APPLY*:

☐ FULL TIME ☐ CLASSIFIED ☐ CONFIDENTIAL ☐ SUBSTITUTE ☐ STUDENT
☐ PART TIME ☐ ACADEMIC ☐ MANAGER/SUPERVISOR ☐ SHORT TERM

***PLEASE ANSWER ALL THE QUESTIONS BELOW AND SUBMIT TO YOUR SUPERVISOR.***

1. DATE OF INJURY/ILLNESS: _____
2. TIME YOU BEGAN WORK: _____ ☐ AM ☐ PM TIME OF INJURY: _____ ☐ AM ☐ PM
3. ADDRESS WHERE INJURY/ILLNESS OCCURRED: _____
4. DEPARTMENT/SITE WHERE EVENT OCCURRED: _____
5. PLEASE STATE SPECIFIC PART OF BODY AFFECTED AND TYPE OF INJURY: _____
6. PLEASE STATE EQUIPMENT, MATERIALS AND/OR CHEMICALS BEING USED WHEN INJURY OCCURRED
7. EXPLAIN THE CIRCUMSTANCES AND/OR ACTIVITY RELATED SPECIFICALLY TO THE INJURY/ILLNESS. DESCRIBE THE SEQUENCE OF EVENTS THAT LED TO THE INCIDENT THAT DIRECTLY AFFECTED THE INJURY/ILLNESS (USE BACK OF FORM IF NECESSARY.) _____
8. WAS ANYONE ELSE INJURED? ☐ NO ☐ YES: (IDENTIFY) _____
9. WHO DID YOU NOTIFY REGARDING THIS ACCIDENT/ILLNESS: _____
10. PLEASE NAME ANY WITNESSES: _____
11. COMMENTS: _____

EMPLOYEE SIGNATURE _____ DATE _____

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 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 at time of hire 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 grabada. En la hoja cubierta de esta forma está la explicación de los beneficios de compensación al trabajador.*

*Ud. también debería haber recibido de su empleador al tiempo de ser empleado un folleto describiendo los beneficios 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 "felonía".**

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Ad *ección Resid* _____
3. City. *Ci* _____ Stat *.* _____ *Código Post* _____
4. Date o *de la les dente).* _____ Tin *a e ocurrió.* _____ p.m.
5. Addre des n of wh happene *ción nde nte.* _____
6. Descri y and part of b *. Descr ión el c afect* _____
7. Social ber. *Núm de ro Soc pl .*
8 Signatur *. Firm e lo.* _____

**Employer--compl ction see l elow. le m esta te la n n abajo.**

9. Nam mploy mbr _____
10. Addr irecci _____
11. Date er iew n q em r s or a vez de la les _____
12. Date pro to empl Fe n q le é ó a eado la petici _____
13. Date e ved form. Fe q em or vió ción al emplea _____
14. Name and of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
15. Insurance Policy number. *El número de la póliza del seguro.* _____
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.

***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 dia 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*

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

Keenan & Associates 8/2004

**EMPLOYER'S COPY**

## Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación para 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. For injuries occurring on or after 1/1/04, 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. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. 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 an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

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

**Vocational Rehabilitation:** If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occured prior to 2004.

**Supplemental Job Displacement Benefit (SJDB):** If you do not return 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 ou your perceutage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

**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, or you can hear recorded information aud a list of local offices by calling **(800) 736-7401.** You may also go to the DWC web site at **www.dir.ca.gov.** Link to Workers' Compensation.

**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.**

Si Ud. se lesiona o se enferma, ya sea física 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 para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para 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/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete 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/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

**Atención Médica:** Su administrador(a) 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(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

**El Médico Primario que le Atiende-*Primary Treating Physician PTP*** es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Siu embargo, en condiciones específicas, es posible que usted pueda sertratado por su médico pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. puede cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas do tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y contiuuará proveyendo este tratamieuto hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha enque el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

**Divulgación de Expedientes Médicos:** Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos un(a) juez de compensación para trabajadores posiblemente decida que expedientes se revelarán. Si Ud. solicita privacidad, es posible que el/la 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. 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 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(a) de noche, o no pueda trabajar durante más de 14 dias.

**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/la administrador(a) 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 extenderse o no temporalmente, 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.

**Rehabilitación Vocacional:** Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

**Beneficio Suplementario por Desplazamiento de Trabajo:** Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habiladad. Si Ud. reúne los requisitios, el administrador(a) de reclamos pagará los costos basta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

**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 vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

**Es ilegal que su empleador** le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de 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 infornación y asistencia, de la División estatal de Compensación al Trabajador *(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 ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

**Ud. puede consultar con un(a) abogado(a).** La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al **(415) 538-2120,** ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org.**

# Covered Employee Notification of Rights Materials

**PRIME Advantage Medical Network – Medical Provider Network ("MPN")**

**This pamphlet contains important information about your medical care in case of a work-related injury or illness.**

## YOU ARE IMPORTANT TO US

A safe working environment is our number one priority. However, should you become injured or ill, as a result of your job, we want to ensure you receive prompt quality medical treatment. Our goal is to assist you in making a full recovery and returning to your job as soon as possible. In compliance with California law, we provide workers' compensation benefits, which include the payment of all appropriate medical treatment for work-related injuries or illnesses. If you have any questions regarding the MPN, please contact **Keenan's MPN Coordinator at 1-800-654-8102.**

## PRIME ADVANTAGE MEDICAL NETWORK - "MPN"

San Bernardino Community College District provides workers' compensation coverage for you in the event you sustain a work-related injury. **PRIME Advantage Medical Network** accesses medical treatment through Prudent Buyer HCO, which utilizes Blue Cross of California's PPO ("Blue Cross") network. Blue Cross has contracted with doctors, hospitals and other providers to respond to the special requirements of on-the-job injuries or illnesses.

Prudent Buyer is a State of California certified Health Care Organization ("Prudent Buyer HCO"), which means that it has met all MPN access and network requirements.

## ACCESS TO CARE

If you should experience a work-related injury or illness, you should:

**Notify your employer:**

Immediately notify your supervisor or employer representative so you can secure medical care. Employers are required to authorize medical treatment within one working day of your filing of a completed claim form (DWC-1). To ensure your rights to benefits, report every injury and request a claim form.

**Initial or Urgent Care:**

- If medical treatment is needed, your employer will direct you to an MPN provider upon initial report of injury. Access to medical care should be immediate but in no event longer than 3 business days.

**For Emergency Care:**

- In the case of emergency* go to the nearest healthcare provider. Once your condition is stable, contact your employer, San Bernardino Community College District, Blue Cross at (866) 700-2168, or **Keenan's MPN Coordinator at (800) 654-8102** for assistance in locating a MPN provider for continued care.

**Emergency care is defined as a need for those health care services provided to evaluate and treat medical conditions of a recent onset and severity that would lead a lay person, possessing an average knowledge of medicine, to believe that urgent care is required.*

**Subsequent Care:**

- All non-medical emergencies, which require ongoing treatment, in-depth medical testing or a rehabilitation program, must be authorized by your claims examiner and based upon medically evidenced based treatment guidelines (American College Of Environmental Medicine "ACOEM" or California Labor Code §5307.27). Access to subsequent care, including specialist services, shall be available within no more than twenty (20) business days.
- If you relocate or move outside of California or outside of the **PRIME Advantage Medical Network** geographic service area and require continued care for your work related injury or illness, you may select a new physician to provide ongoing care or you may contact your claims examiner for assistance with locating a new primary care physician. If your relocation or move is temporary upon your return to California should you require ongoing medical care, immediately contact your claims examiner or your employer so arrangements can be made to return you to your prior MPN provider or, if necessary, for assistance in locating a new MPN provider for continued care.

**If you are temporarily working outside of California and are injured:**

- If you are working outside of California and experience work related injury or illness, notify your employer. For initial, urgent or emergency care, or follow up care, go to the nearest healthcare provider for medical treatment.
- If you need assistance locating a physician or should the physician you select need authorization to provide care to you, call **Keenan's MPN Coordinator at (800) 654-8102** and we will assist you. Upon your return to California, should you require ongoing medical care, immediately contact your claims examiner or your employer for referral to an MPN provider for continued care.

## HOW TO CHOOSE A PHYSICIAN WITHIN THE MPN

The MPN has providers for the entire state of California. The MPN must give you a regional list of providers that includes at least 3 physicians in each specialty commonly used to treat work related injuries or illnesses in your industry. The MPN must provide access to primary physicians within 15 miles and specialists within 30 miles. To locate a participating provider or obtain a regional listing:

**Provider Directories:**

- On-line Directories – if you have internet access, you may obtain a regional directory or locate a participating provider near you by visiting www.keenan.com and clicking on 'Keenan Solutions -Products and Services' then the 'Workers' Compensation' option and then the 'PRIME Advantage MPN for School Clients" option or www.bclhwcmcs.com, and clicking on the 'Provider Finder' tab.
- If you do not have internet access, you may request assistance locating an MPN provider or obtaining an appointment by calling **Keenan's MPN Coordinator at (800) 654-8102** or Blue Cross at (866) 700-2168.
- Promptly contact your claims examiner to notify us of any appointment you schedule with an MPN provider.

**Choosing a Physician (for all initial and subsequent care):**

- Your employer will direct you to an MPN provider upon initial report of injury. You have the right to be treated by a physician of your choice within the MPN ***after your initial visit***.
- If you wish to change your MPN physician after your initial visit, you may do so by:
  - Accessing the on-line provider directories (see above)
  - Contacting your claims examiner or **Keenan's MPN Coordinator at (800) 654-8102**
  - Contacting Blue Cross at (866) 700-2168 to locate an MPN provider
- If you select a new physician, immediately contact your claims examiner and provide him or her with the name, address and phone number of the physician you have selected. You should also provide the date and time of your initial evaluation.
- If it is medically necessary for your treatment to be referred to a specialist, your MPN physician will make the appropriate referral within the network.
- If a type of specialist is recommended by your MPN physician, but is not available to you within the network, your claims examiner will work with you and your MPN physician to locate a specialist outside of the network, schedule an appointment and notify you of the date and time, or you may select the appropriate specialist and notify us of your selection. Your MPN physician, who is your primary care physician, will continue to direct all of your medical treatment needs.

## SECOND AND THIRD OPINIONS

**Second Opinion:**

- If you disagree with either the diagnosis or the treatment prescribed by your MPN physician, you may obtain a second opinion within the MPN. During this process you are required to continue your treatment with an MPN physician of your choice. In order to obtain a second opinion you have some responsibilities:
  - Inform your claims examiner of your dispute regarding your treating physician's opinion either orally or in writing.
  - You are to select a physician or specialist from a regional list of available MPN providers, which will be provided to you by your claims examiner upon notification of your request for a second opinion.
  - You are to make an appointment within 60 days.
  - You are to inform your claims examiner of the appointment date and time.

- You may waive your right to a second opinion if you do not make an appointment within 60 days from receipt of the list. You have the right to request a copy of the medical records sent to the second opinion physicians.

**Third Opinion:**

- If you disagree with either the diagnosis or the treatment prescribed by your MPN physician, you may obtain a third opinion within the MPN. During this process you are required to continue your treatment with an MPN physician of your choice. In order to obtain a third opinion you have some responsibilities:

- Inform your claims examiner of your dispute regarding your treating physician's opinion either orally or in writing.
- You are to select a physician or specialist from the list of available MPN providers previously provided or you may request a new regional area list.
- You are to make an appointment within 60 days.
- You are to inform your claims examiner of the appointment date and time.
- You may waive your right to a third opinion if you do not make an appointment within 60 days from receipt of the list.
- You have the right to request a copy of the medical records sent to the third opinion physician.

- At the time of selection of the physician for a third opinion, your claims examiner will notify you about the Independent Medical Review process and provide you with an application for the Independent Medical Review process (see below).

## INDEPENDENT MEDICAL REVIEW (IMR)

If you disagree with the diagnosis service, diagnosis or treatment provided by the third opinion physician, you may request an Independent Medical Review (IMR). An IMR is performed by a physician identified for you by the Administrative Director (AD) with the Division of Workers' Compensation Medical Unit of the State of California. To request an IMR you will be required to complete and file a Medical Review Application with the AD. The AD will select an IMR who has the appropriate specialty necessary to evaluate your dispute. The AD will send you written notification of the name, address and phone number of the IMR.

You may choose to be seen by the IMR in person or you may request that the IMR only review your medical records. Whichever you choose, you will be required to contact the IMR for an appointment. Your IMR should see you within 30 days from your request for an appointment. The IMR will send his/her report to the AD for review and a determination will be made regarding the dispute.

You may waive your right to the IMR process if you do not schedule an appointment within 60 calendar days from receiving the name of the IMR from the AD.

## CONTINUITY OF CARE POLICY

San Bernardino Community College District will, at the request of a covered injured employee, provide for the completion of treatment by a *terminated MPN physician* or provider in accordance with Labor Code §5307.27 and the adopted medical treatment guidelines.

The completion of treatment will be provided by a terminated provider to a covered injured employee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described below, unless the provider was terminated or non-renewed for reasons related to disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of *Section 805 of the Business and Professions Code*, or fraud or other criminal activity.

(A) ***An acute condition.*** An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of treatment shall be provided for the duration of less than ninety (90) days.

(B) ***A serious chronic condition***. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over a period of at least (90) days or requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the insurer or employer in consultation with the injured employee and the terminated provider and consistent with good professional practice. Completion of treatment

under this paragraph shall not exceed 12 months from the contract termination date.

(C) ***A terminal illness***. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

***Performance of a surgery or other procedure*** that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

San Bernardino Community College District may make a determination whether an injured covered employee's treatment should be transferred to a physician or provider within the MPN if the above conditions are not met. Whether or not the injured covered employee is required to select a new physician or provider in the MPN, San Bernardino Community College District will notify the covered injured employee in writing in both English and Spanish and use lay terms to the maximum extent possible of the determination providing a copy of the determination to the injured covered employee's primary treating physician, and to the employee's residence.

If the terminated provider *agrees to continue treating* the injured covered employee in accordance with (A) through (D) of this policy, and if the injured covered employee *disputes* the medical determination made by San Bernardino Community College District, the injured covered employee shall request a report from his/her primary treating physician that addresses whether he/she falls within any of the conditions set forth in (A) through (D).

If the treating physician **does not agree** with the determination made by San Bernardino Community College District that the injured covered employee's medical condition does not meet the conditions set forth in (A) through (D), the injured covered employee shall continue to treat with the terminated provider until the dispute is resolved.

If the treating physician *agrees* with the determination made by San Bernardino Community College District that the injured covered employee's medical condition does not meet the conditions set forth in (A) through (D), the transfer of care shall go forward during the dispute resolution process.

If the treating physician *fails* to provide a report the covered injured employee within 20 calendar days of the request from the covered injured employee, the determination made by San Bernardino Community College District shall apply.

Disputes regarding the medical determination made by the treating physician concerning the continuity of care policy shall be resolved pursuant to Labor Code §4062. A copy of this policy is available upon request.

## TRANSFER OF CARE POLICY

For injured covered employees who are being treated outside of the MPN for an occupational injury or illness that occurred prior to the effective date of MPN, San Bernardino Community College District will provide for the completion of treatment as noted below.

(A) If the injured covered employee is being treated by a physician or provider prior to the implementation of the MPN and the injured covered employee's physician or provider **becomes** a contracted provider within the MPN, the injured covered employee and their physician shall be notified that his/her treatment is being provided under the provisions of the MPN.

(B) Injured covered employees who are being treated by a physician or provider outside of the MPN for an occupational injury or illness that occurred prior to the effective date of the MPN, including injured covered employees who pre-designated a physician and do not fall within Labor Code §4600(d), will continue to be treated outside the MPN for the following conditions:

I. ***An acute condition***. Is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of less than ninety (90) days. Completion of treatment shall be provided for the duration of the acute condition.

II. ***A serious chronic condition***. A serious chronic condition is a medical condition due to a disease, illness, catastrophic injury, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over ninety (90) days and requires ongoing treatment to maintain remission or

prevent deterioration. Completion of treatment will be provided for a period of time, necessary, up to one year from the covered employee's receipt of notification:

(A) to complete a course of treatment approved by San Bernardino Community College District and

(B) to arrange for transfer to another provider within the MPN, as determined by San Bernardino Community College District. The one-year period for completion of treatment starts from the date of the injured employee's receipt of the notification, as required by subdivision (f), of the determination that an injured covered employee has a serious chronic condition as defined.

III. ***A terminal illness***. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

IV. ***Performance of a surgery or other procedure*** that is authorized by San Bernardino Community College District as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days from the MPN coverage effective date.

San Bernardino Community College District may make a determination whether an injured covered employee's treatment should be transferred to a physician within the MPN if the above conditions are not met. All transfer of care determinations will be in writing in both English and Spanish and use lay terms to the maximum extent possible, and will be sent to the injured covered employee's residence and a copy of the letter shall be sent to the injured covered employee's primary treating physician. If the injured covered employee disputes a transfer determination made by San Bernardino Community College District, he/she must request a report from the their primary treating physician that addresses whether the injured covered employee falls within any of the conditions set forth in (I) through (IV).

1) If the treating physician **agrees** with the determination made by San Bernardino Community College District that the injured covered employee's medical condition does not meet the conditions set forth in (I) through (IV), the transfer of care shall go forward during the dispute resolution process.

2) If the treating physician **does not agree** with the determination made by San Bernardino Community College District that the injured covered employee's medical condition does not meet the conditions set forth in (I) through (IV), the transfer of care shall not go forward until the dispute is resolved.

3) If the treating physician fails to provide a report to the covered injured employee within 20 calendar days of the request from the covered injured employee, the determination made by San Bernardino Community College District shall apply.

Until the injured covered employee is transferred into the MPN, the employee's physician may make referrals to providers within or outside the MPN. Disputes regarding the medical determination made by the treating physician concerning the transfer of care shall be resolved pursuant to Labor Code §4062. A copy of this policy is available upon request.

## KEENAN & ASSOCIATES ADJUSTING LOCATIONS

**Torrance:** 800-654-8102

**Eureka:** 707-268-1616

**Rancho Cordova:** 800-343-0694

**Redwood City:** 650-306-0616

**Riverside:** 800-654-8347

**San Jose:** 800-334-6554

## MEDICAL DIRECTORY USER ID AND PASSWORD INFORMATION

When locating participating providers on-line, through the Internet, a user id and password is required to ensure that you are provided correct information.

User ID: special

Password: **access**

SAN BERNARDINO COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

# AUTHORIZATION FOR MEDICAL TREATMENT

**WORK-RELATED EMPLOYEE INJURY**

***EMPLOYEE PERSONAL INFORMATION***

EMPLOYEE NAME: _____ EMPLOYMENT SITE: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ ☐ AM ☐ PM

WORKING DAYS: _____ WORKING HOURS: _____

***IMPORTANT - CHOOSE ONE OPTION LISTED BELOW:***

☐ **I ACCEPT** MEDICAL TREATMENT AT A CLINIC DESIGNATED BY THE SAN BERNARDINO COMMUNITY COLLEGE DISTRICT AS LISTED BELOW. *PLEASE SELECT ONE OF THE CLINICS BELOW BY CHECKING THE APPROPRIATE BOX.*

☐ **I DECLINE** MEDICAL TREATMENT AT THIS TIME. ADDITIONALLY, I UNDERSTAND THAT IF I SHOULD NEED MEDICAL TREATMENT AT A LATER DATE I WILL NOTIFY MY SUPERVISOR AND HUMAN RESOURCES.

☐ I CHOOSE TO BE TREATED BY THE **PRE-DESIGNATED PHYSICIAN**, AS NOTED BELOW. I UNDERSTAND THAT THIS DESIGNATION MUST BE ON FILE WITH HUMAN RESOURCES PRIOR TO THE DATE OF THIS INJURY AND THAT PHYSICIAN I HAVE CHOSEN HAS PREVIOUSLY TREATED ME, HAS MY MEDICAL RECORDS AND HAS AGREED TO TREAT ME IN THE EVENT OF A WORK-RELATED INCIDENT.

*NOTE: USE OF AN UNAUTHORIZED MEDICAL FACILITY MAY RESULT IN NON-PAYMENT OF THE BILL.*

| √ | NAME | ADDRESS (MAPS ON BACK SIDE) | PHONE | HOURS |
|---|---|---|---|---|
| ☐ | COMP – CENTRAL OCCUPATIONAL MEDICINE PROVIDERS | 201 E. AIRPORT DR, STE C<br>SAN BERNARDINO, CA 92408<br>**OTHER LOCATIONS AVAILABLE** | 909-723-1161 | 24 HOURS<br>7 DAYS/WEEK |
| ☐ | PRE-DESIGNATED PHYSICIAN | THIS OPTION AVAILABLE ONLY IF A PRE-DESIGNATION FORM SIGNED BY YOUR DOCTOR IS CURRENTLY ON FILE WITH HUMAN RESOURCES | | |

**I HAVE BEEN GIVEN THE FOLLOWING FORMS:**

1. State Claim Form DWC – 1
2. Medical Treatment Authorization Form
3. Instructions for Injured Workers
4. Covered Employee Notification of Rights Materials (MPN)

EMPLOYEE SIGNATURE: _____ DATE: _____

AUTHORIZED SUPERVISOR (PRINT): _____ TITLE: _____

SUPERVISOR SIGNATURE: _____ DATE: _____

---

**INSTRUCTIONS TO MEDICAL PROVIDER:** MAIL ORIGINAL DOCTOR'S FIRST REPORT AND ALL MEDICAL BILLS TO:

***FIRST AID CLAIMS ONLY:***
SBCCD, ATTN: HUMAN RESOURCES
114 S. DEL ROSA DR.
SAN BERNARDINO, CA 92408

***RECORDABLE CLAIMS:***
KEENAN & ASSOCIATES
PO BOX 59916
RIVERSIDE, CA 92517

951-715-0190
JESSICA REYNOSO, EXT 1107
951-788-8013 (FAX)

***DISTRIBUTION:*** ***ORIGINAL: MEDICAL PROVIDER (IF DECLINING TREATMENT –SEND TO HR)*** ***COPY: FAX TO SBCCD HR 909-382-0173*** ***COPY: EMPLOYEE***

San Bernardino Community College District

**Office of Human Resources**
114 S. Del Rosa Drive; San Bernardino CA 92408
Phone 909-382-4040 Fax 909-382-0173

# IN CASE OF WORK RELATED INJURY

## Open 24-Hours - 7 Days a Week

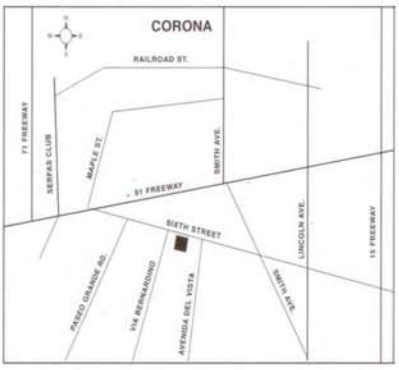
**Physicals & Follow Up Appointments - Monday thru Friday: 8:00am - 6:00pm**

COMP

## Central Occupational Medicine Providers

**website - http:// www.comp-medicalgroup.com**


4300 CENTRAL AVENUE • RIVERSIDE, CA 92506
**(951) 222-2206 • FAX (951) 222-2106**

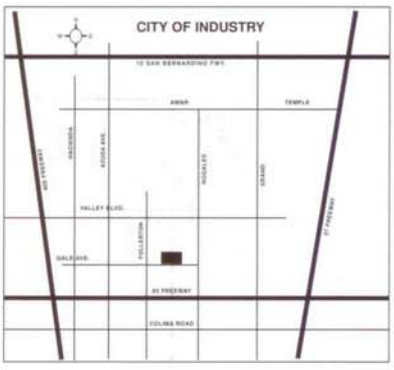



1690 WEST 6TH STREET, STE. K • CORONA, CA 92882
**(951) 736-9500 • FAX (951) 736-9512**


59 South Milliken Ave., Suite 100 • Ontario, CA 91761
**(909) 605-8888 • FAX (909) 605-8855**


13800 Heacock Ave., Suite C134 • Moreno Valley, CA 92553
**(951) 656-6009 • FAX (951) 656-6010**


201 E. Airport Drive, Suite C • San Bernardino, CA 92408
**(909) 723-1161 • FAX (909) 723-1168**




18575 E. Gale Ave., Ste 155 • City of Industry, CA 91748
**(626) 581-8960 • FAX (626) 581-8536**

## Courtesy Transportation Available For Injuries

***Please be aware:*** *Workers' Compensation Senate Bill 1218 Fraudulent Claims:*
*Anyone filing a false claim is guilty of a felony. The penalty will be up to 5 years in jail or up to $50,000.00 in fines.*

SAN BERNARDINO COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

# SUPERVISOR INSTRUCTIONS FOR MANAGING INJURED WORKERS

1. IN THE EVENT OF A LIFE THREATENING EMERGENCY, IMMEDIATELY CONTACT
   - VALLEY COLLEGE X 4491
   - CRAFTON HILLS COLLEGE X 3275
   - DISTRICT/ANNEX/ETC/ARF X 911
     PROF. DEVELOPMENT BLDG

2. CONTACT THE HUMAN RESOURCES OFFICE AT 909-382-4040 TO INITIATE THE PROCESS.
   *CAL-OSHA IS TO BE CONTACTED WITHIN 8 HOURS OF THE EMPLOYERS KNOWLEDGE OF AN EMPLOYEE BEING HOSPITALIZED OR SEVERLY INJURED. IF NOTIFICATION IS NECESSARY ON THE WEEKEND, YOU MUST CONTACT THEM BY CALLING 909-383-4321.*

3. PROVIDE THE EMPLOYEE THE FOLLOWING PAPERWORK:

   ✓ ***COVERED EMPLOYEE NOTIFICATION OF RIGHTS MATERIALS (MPN)***

   ✓ ***EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***
   - THIS IS AN INTERNAL FORM THAT MUST BE FILLED OUT BY THE EMPLOYEE ANYTIME YOU ARE NOTIFIED THAT AN INJURY, ILLNESS OR ACCIDENT OCCURRED, REGARDLESS OF THE EMPLOYEE'S INTENT TO SEEK MEDICAL CARE. THE EMPLOYEE MUST FILL OUT THIS FORM IMMEDIATELY.

   ✓ ***ORIGINAL WORKERS COMPENSATION CLAIM FORM (DWC-1)***
   - COMPLETE EMPLOYEE NAME AND NUMBERS 9-17 ON THE FORM.
     - THE FOLLOWING INFORMATION SHOULD BE USED FOR ITEMS 13 AND 14:
       KEENAN & ASSOCIATES; PO BOX 59916; RIVERSIDE CA 92517
       INSURANCE POLICY NUMBER: NOT APPLICABLE
   - IT IS EXTREMELY IMPORTANT FOR THE EMPLOYEE TO RETURN THE DWC-1 FORM AS SOON AS POSSIBLE IN ORDER TO RECEIVE BENEFITS TIMELY
     - IF THE EMPLOYEE <u>DOES NOT WANT</u> TO FILE A CLAIM, GIVE THE EMPLOYEE THE GREEN AND PINK COPIES. SEND THE WHITE AND YELLOW COPIES TO HUMAN RESOURCES.
     - IF THE EMPLOYEE <u>DOES WANT</u> TO OPEN A CLAIM, HAVE THEM FILL OUT THE TOP SECTION BEFORE GIVING THEM THE PINK AND GREEN COPIES. SEND THE WHITE AND YELLOW COPIES TO HUMAN RESOURCES.

   ✓ ***AUTHORIZATION FOR MEDICAL TREATMENT***
   - THE EMPLOYEE SHOULD COMPLETE THE TOP SECTION AND CHECK THE APPROPRIATE BOXES REGARDING MEDICAL TREATMENT.
   - MAKE SURE TO PRINT YOUR NAME AND TITLE, AND SIGN THE FORM TO AUTHORIZE TREATMENT.

4. FOLLOW THE DISTRIBUTION INSTRUCTIONS ON THE BOTTOM OF THIS FORM AND ENSURE THE EMPLOYEE HAS RECEIVED ALL THE LISTED FORMSFILL OUT THE ***SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***.

5. PROVIDE THE ***WITNESS REPORT OF INJURY*** TO ANY IDENTIFIED WITNESSES.

6. FAX ALL OF THE FORMS TO THE HUMAN RESOURCES OFFICE IMMEDIATELY AND MAIL THE HARD COPIES TO THE HUMAN RESOURCES OFFICE WITHIN 24 HOURS. THE FORMS THAT SHOULD BE INCLUDED ARE:
   - ✓ ***EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***
   - ✓ ***SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***
   - ✓ ***WORKERS COMPENSATION CLAIM FORM (DWC-1)***
   - ✓ ***AUTHORIZATION FOR MEDICAL TREATMENT***
   - ✓ ***WITNESS REPORT OF INJURY*** *(IF APPLICABLE)*

7. THE COLLEGE DOES HAVE A RETURN TO WORK PROGRAM AND SUPERVISORS MAY BE ASKED TO PARTICIPATE IN DISCUSSIONS REGARDING TEMPORARY MODIFIED DUTY

NOTES:

- ANY DOCTOR'S NOTES, APPOINTMENTS NOTICES, OR TEMPORARY/MODIFIED DUTY SLIPS RECEIVED AT THE SITE MUST BE FORWARDED TO THE HUMAN RESOURCES OFFICE IMMEDIATELY
- ANY MODIFIED DUTY REQUIRES COORDINATION WITH HUMAN RESOURCES BEFORE THE EMPLOYEE MAY RETURN TO WORK
- PLEASE MARK TIMECARDS ACCORDINGLY IF THE EMPLOYEE IS OUT FOR ANY INDUSTRIAL INJURY REASONS

**IF YOU HAVE ANY QUESTIONS, CONTACT HUMAN RESOURCES AT 909-382-4040**

SAN BERNARDINO COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

# SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

***PLEASE ANSWER ALL THE QUESTIONS BELOW AND SUBMIT TO HUMAN RESOURCES WITHIN 24 HOURS.***

EMPLOYEE NAME: _____ EMPLOYMENT SITE: _____

OCCUPATION: _____ DATE REPORTED: _____

DATE OF INJURY: _____ ON EMPLOYER'S PREMISES? ☐ NO ☐ YES

TIME OF INJURY: _____ ☐ AM ☐ PM TIME EMPLOYEE BEGAN WORK _____ ☐ AM ☐ PM

WAS ANYONE ELSE INJURED? ☐ NO ☐ YES SPECIFY NAME(S): _____

12. WHERE DID ACCIDENT/ILLNESS/EXPOSURE OCCUR: _____
13. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED: _____

_____

14. EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN EVENT/EXPOSURE/ILLNESS OCCURRED:

_____

15. SPECIFIC ACITIVITY EMPLOYEE WAS PERFORMING WHEN EVENT/EXPOSURE/ILLNESS OCCURRED: _____

_____

16. HOW INJURY/ILLNESS OCCURRED (DESCRIBE SEQUENCE OF EVENTS, SPECIFIC OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS.) **USE SEPARATE SHEET IF NECESSARY** _____

_____

_____

_____

17. WAS A DOCTOR SEEN? ☐ NO ☐ YES, PLEASE IDENTIFY BELOW:
    ☐ US HEALTHWORKS ☐ LOMA LINDA OCCUP MED CTR ☐ PRE-DESIGNATED PHYSICIAN
    ☐ CLOSEST HOSPITAL: _____ HOSPITALIZED? ☐ NO ☐ YES
18. WAS FIRST AID APPLIED? ☐ NO ☐ YES, DESCRIBE: _____
19. WAS EMPLOYEE UNABLE TO WORK ON ANY DAY **AFTER** INJURY? ☐ NO ☐ YES LAST DAY WORKED _____
20. HAS EMPLOYEE RETURNED TO WORK? ☐ NO, STILL OFF WORK ☐ YES, DATE _____
21. WAS THE ACCIDENT PREVENTABLE? ☐ NO ☐ YES, EXPLAIN _____

_____

22. WHAT STEPS HAVE BEEN TAKEN TO PREVENT SIMILAR ACCIDENTS? _____

_____

_____

SUPERVISOR SIGNATURE _____ DATE _____

SAN BERNARDINO COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

# WITNESS STATEMENT OF EMPLOYEE INJURY

WITNESS NAME: _____ CONTACT PHONE: _____

JOB TITLE: _____ DISTRICT EMPLOYEE? ☐ YES ☐ NO

HOME ADDRESS: _____

NAME(S) OF INJURED EMPLOYEES: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ ☐ AM ☐ PM

SITE AND EXACT LOCATION OF ACCIDENT: _____

23. PLEASE DESCRIBE THE ACCIDENT: _____

_____

_____

_____

_____

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_____

_____

24. IN YOUR OPINION, WHAT WERE THE CONTRIBUTING CAUSES TO THE ACCIDENT? _____

_____

_____

_____

_____

_____

25. PLEASE NAME ANY OTHER WITNESSES: _____

_____

WITNESS SIGNATURE _____ DATE _____

# WORKER TRAINING AND INSTRUCTION RECORD

| Worker's Name | Training Dates | Type of Training | Trainers |
|---|---|---|---|
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