SAN JOAQUIN COUNTY PROBATION DEPARTMENT
ADMINISTRATIVE MANUAL

TO: ALL STAFF

BULLETIN #: 210

APPROVED BY: STEPHANIE L. JAMES
CHIEF PROBATION OFFICER

REPLACES: 2/21/06

ISSUE DATE: 9/14/15

SUBJECT: ACCIDENT/INJURY/JOB RELATED ILLNESS REPORTING PROCEDURES

POLICY

All accidents and injuries occurring during work hours must be reported as soon as possible by staff to their supervisors. Guidelines for reporting accidents and injuries are addressed in Sections 101 and 103 of the County Administrative Manual.

PROCEDURES

A. INDUSTRIAL INJURY OR ILLNESS (INCLUDING JOB-RELATED STRESS):

1. When an employee is involved in an Industrial injury or illness, the Unit Supervisor and the employee (if available) shall complete the following documents and submit to the Office Secretary within 24 hours:

   a. San Joaquin County Employee Request for Medical Treatment (Attachment A).
   c. San Joaquin County Probation Department Supervisor’s Incident Report Form (Attachment C).
   e. San Joaquin County Doctor’s Physical Restriction Form (Attachment E).

      i. This form will be given to the employee by his/her supervisor. However, the use of this form is optional as the employee’s physician may choose to document restriction(s) by other means.
      ii. Whichever method is used, the employee must submit documentation of physical restrictions signed by a physician.
f. County’s Notice of Leave of Absence for Temporary Disability Indemnity Payment (Attachment F). This form is only required when the employee is requesting a Leave of Absence.

2. Using the information provided, the designated Office Secretary will complete the State of California Employer’s Report of Occupational Injury or Illness form 5020.

3. The Office Secretary will send copies of all forms to the Department Safety and Health Representative, with a copy to the Chief Probation Officer and Assistant Chief Probation Officer.

4. The Office Secretary retains a copy of all forms in the employee’s medical file and sends the originals to Human Resources, Attention: Risk Management within 24 hours.

5. A copy of the County’s Notice of Leave of Absence for Temporary Disability Indemnity Payment (Attachment F) is also sent to the Payroll Unit.

B. VEHICLE ACCIDENTS, LOSS AND/OR INJURY

1. If a County employee is injured while operating a county vehicle on the job, the procedures described above under Industrial Injury or Illness must be followed. The employee must also complete the Automobile Accident form (Attachment G).

2. If a non-employee is not claiming an injury and declines medical treatment, complete the San Joaquin County Incident Report (Attachment H) and forward to the appropriate Office Secretary.

C. INJURY TO NON-EMPLOYEE (INCLUDING ARRESTEES)

Any employee aware of such an injury on County property or in the course of business with the County must complete the San Joaquin County Probation Incident Report form must be completed (Attachment H).

D. ACCIDENTS, LOSS OR INJURY, WHICH CONSTITUTES A CRIME

Any employee aware of such occurrence on County property or in the course of business for or with the County must also report it to local law enforcement.

E. INJURY TO YOUTH OR VOLUNTEERS

Volunteers on County business and youth assigned to court-ordered work projects are normally covered by Workers Compensation. Staff supervising them must complete any required forms listed above in the event of injury.
SAN JOAQUIN COUNTY
EMPLOYEE REQUEST for MEDICAL TREATMENT

TO: Doctor ________________________________

Doctor's Address ________________________________

________________________, while in our employ

(Employee)

is requesting medical treatment for incident occurring

________________________ (Date)  _____________________________ (Time)

A Workers' Compensation claim has been filed. Please complete and
send the "Doctor's First Report of Work Injury" to San Joaquin County
Human Resources, Risk Management, 24 S. Hunter St., Room 106,
Stockton, CA 95202.

FROM: EMPLOYER: San Joaquin County

DEPARTMENT: ________________________________

ADDRESS: 24 S. Hunter St., Rm. 106, Stockton, CA 95202

BY: ________________________________ (Date)

(Supervisor)

* * * * * * * * * * * * * * * * * * * * * *

OR: "I have declined the offer of professional medical treatment at
this time."

________________________ (Employee's Signature)  _____________________________ (Date)

Distribution: Original .................. Doctor
Yellow .... Human Resources
Pink .................. Retain

S&T 201 (2/99)
# Accident/Injury/Job Related Illness Reporting Procedures

## Probation Department
COUNTY OF SAN JOAQUIN

**INSTRUCTIONS:** This form is designed to be completed on a computer. You may either tab or mouse click to areas of the form to complete. Some fields have drop-down menus. Boxes will automatically resize to allow sufficient space for narrative. Report is then printed, signed and distributed as indicated below. Remember to save form with a new name and date before closing. **Submit report as soon as possible, even though some documents or information may not be readily available.**

<table>
<thead>
<tr>
<th>NAME (L, F, MI)</th>
<th>CAPS ID#</th>
<th>CLASSIFICATION</th>
<th>DIVISION</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATE, TIME OF ACCIDENT</th>
<th>TIME LOST FROM WORK?</th>
<th>VEHICLE ACCIDENT?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Yes [ ] No</td>
<td>[ ] Yes [ ] No</td>
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</tbody>
</table>

If yes, attach Accident/Loss Report S&T 207

<table>
<thead>
<tr>
<th>LOCATION</th>
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<td>[ ] Yes [ ] No</td>
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<table>
<thead>
<tr>
<th>DESCRIBE INJURY &amp; PART OF BODY AFFECTED:</th>
</tr>
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<tbody>
<tr>
<td>AGENCY &amp; REPORT # (If Applicable):</td>
</tr>
</tbody>
</table>

**DETAILED DESCRIPTION OF ACCIDENT** (Who, what where, how, why), attach additional sheet(s) if necessary

<table>
<thead>
<tr>
<th>WITNESSES: Check if none: [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME(S):</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>ADDRESS:</th>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<tr>
<th>PHONE:</th>
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<tr>
<td>1.</td>
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<td>2.</td>
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**WAS FIRST AID/MEDICAL ATTENTION GIVEN?**

<table>
<thead>
<tr>
<th>[ ] Yes [ ] No</th>
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<table>
<thead>
<tr>
<th>BY WHOM?</th>
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<td>1.</td>
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<td>2.</td>
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<tr>
<th>DR.'S OFFICE/HOSPITAL ADDRESS</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
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</table>

**WHERE?**

<table>
<thead>
<tr>
<th>1. On scene</th>
<th>2. Dr.'s Office/Hospital</th>
</tr>
</thead>
</table>

**CAUSE OF ACCIDENT - INCIDENT** (unsafe acts/conditions):

**MEDICAL TREATMENT:**

[ ] I request professional medical treatment at this time.

[ ] I decline medical treatment at this time.

Signature: __________________________ Date: ____________

<table>
<thead>
<tr>
<th>PHYSICIAN INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
</tr>
<tr>
<td>ADDRESS:</td>
</tr>
<tr>
<td>PHONE:</td>
</tr>
</tbody>
</table>

**DATE LAST WORKED:** ____________ **DATE RETURNED TO WORK:** ____________ **TIME EMPLOYEE BEGAN:** ____________

<table>
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<tr>
<th>SUPERVISOR:</th>
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<tr>
<td>Signature:</td>
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<tr>
<td>Date:</td>
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<tr>
<th>DEPARTMENT HEAD OR DESIGNEE</th>
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<tbody>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

Note: Completion / signing of this form is not an admission of liability by the County or the employee.

**When completed, please route to the Division Secretary**

[ ] Request for Medical Treatment (ST-201)

[ ] Complete: distribute e-5030 form, if applicable

[ ] Complete & distribute DWC Form 1, if applicable

[ ] If vehicle accident, complete & distribute form S&T 207

[ ] Return to work clearance from treating physician, if applicable

[ ] Doctor's Physical Restriction Form, if applicable

**Distribution:**

- Original to Division File
- Copy - Supervisor
- Copy – Appropriate ADCPO
- Copy – Safety and Health Representative

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Attachment B
#210 Accident/Injury/Job Related
Illness Reporting Procedures

Attachment C
#210 Accident/Injury/Job Related Illness Reporting Procedures
Workers’ Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers’ compensation benefits. Use the attached form to file a workers’ compensation claim with your employer. You should read all of the information below. Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the “Employee” section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was received and when it was delivered. Within two working days after you file the claim form, your employer must complete the “Employer” section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

• If you were previously designated your personal physician or a medical group, you may see your personal physician or the medical group you are injured.
• If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of healthcare providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
• If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
• If your employer has not put up a poster describing your rights to workers’ compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator does not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

• If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
• If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to another doctor up to five times after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).

If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choosing if

En Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. Ud. debe leer toda la información a continuación. Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de ellos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, 1 administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional. Para presentar un reclamo, lleve la sección del formulario designada para el “Empleador,” guárdela una copia, y déle el resto a su empleador. Haga este de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se inician hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión de manera completa. Incluya cada parte de su cuerpo afectada por la lesión. Si Ud. le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si Ud. compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el “Empleador,” le dará a Ud. una copia firmada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quirúrgica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atienda (Primary Treating Physician: PTP) es el médico con la responsabilidad total para tratar su lesión o enfermedad.

• Si usted designó previamente a su médico personal en un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
• Si su empleador está utilizando una red de proveedores médicos (Medical Provider Network: MPN) o una Organización de Cuidado Médico (Health Care Organization- HCO), en la mayoría de los casos, usted será tratado en la MPN o HCO a menos que usted haga una designación previa de su médico personal o grupo médico. Una MPN es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si es tratado por una HCO o una MPN. Hable con su empleador para más información.
• Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que le atienda primero a menos que usted haya hecho una designación previa de su médico personal o grupo médico.
• Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Si Ud. no tiene seguro médico, hable con su médico personal o grupo médico. Ellos buscarán reembolso del administrador de reclamos. Si Ud. no tiene seguro médico, hable con su hospital o que le trataron sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

En cambio a esto: Médico Primario o PTP:

• Si usted está recibiendo tratamiento en una Red de Proveedores Médicos...
Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don’t agree to voluntarily release medical records, a workers’ compensation judge may decide what records will be released. If you request privacy, the judge may “seal” (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see “Learn More About Workers’ Compensation,” below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the form request included with the claims administrator’s written decision to deny treatment. The IMR process is semi-automatic, it involves the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP’s opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Not Wages): If you can’t work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly payroll, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/34, and your injury results in a permanent disability and your employer does not provide an alternative job, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a beneficiary as designated by you (Medical Provider Network - MPN), the employer, the MPN, the HCO, or the employee beneficiary. Payment of death benefits can be made to a beneficiary as designated by the claims administrator. In the event of death, the MPN, the HCO, or the employee beneficiary can make a claim for death benefits. The amount of the claim will be determined by the claims administrator. The claims administrator will also provide you with a list of beneficiaries to whom the death benefits can be paid. You can make a claim for death benefits using the form provided by the claims administrator. The claim must be filed within 1 year of the date of death. The amount of the claim will be determined by the claims administrator. The claims administrator will also provide you with a list of beneficiaries to whom the death benefits can be paid. You can make a claim for death benefits using the form provided by the claims administrator. The claim must be filed within 1 year of the date of death. The amount of the claim will be determined by the claims administrator. The claims administrator will also provide you with a list of beneficiaries to whom the death benefits can be paid. You can make a claim for death benefits using the form provided by the claims administrator. The claim must be filed within 1 year of the date of death.
spouse and other relatives or household members who were financially dependent on the deceased worker.

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

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers’ compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers’ Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

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

Learn More About Workers’ Compensation: For more information about the workers’ compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, “Workers’ Compensation in California: A Guidebook for Injured Workers.” You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

Attachment D

#210 Accident/Injury/Job Related
Illness Reporting Procedures

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Illness Reporting Procedures

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#210 Accident/Injury/Job Related
Illness Reporting Procedures

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Rev. 1/1/2016
**WORKERS’ COMPENSATION CLAIM FORM ( DWC 1 )**

**Employer:** Complete the “Employer” section and give the form to your employer. Keep a copy and mark it “Employer’s Temporary Receipt” until you receive the signed and dated copy from your employer. You may call the Division of Workers’ Compensation and hear recorded information at (800) 736-7401. An explanation of workers’ compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference. You should also have received a pamphlet from your employer describing workers’ compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive those 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.

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

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

1. **Name, Nombre:**  
2. **Home Address, Dirección Residencial:**  
3. **City, Ciudad:**  
4. **Date of Injury, Fecha de la lesión (accidente):**  
5. **Address and description of where injury happened, Dirección/lugar donde ocurrió el accidente:**

6. **Describe injury and part of body affected, Describa la lesión y parte del cuerpo afectada:**

7. **Social Security Number, Número de Seguro Social del Empleado:**

8. **Check if you agree to receive notices about your claim by email only, Remarcando usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico, Empleado’s e-mail:**

9. **Signature of employee, Firma del empleado:**

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

10. **Name of employer, Nombre del empleador:**  
11. **Address, Dirección:**  
12. **Date employer first knew of injury, Fecha en que el empleador supo por primera vez de la lesión o accidente:**

13. **Date claim form was provided to employee, Fecha en que se le entregó al empleado la petición:**

14. **Date employer received claim form, Fecha en que el empleado devolvió la petición al empleador:**

15. **Name and address of insurance carrier or adjusting agency, Nombre y dirección de la compañía de seguros o agencia administradora de seguros:**

16. **Insurance Policy Number, El número de la póliza de Seguro:**

17. **Signature of employer representative, Firma del representante del empleador:**

18. **Title, Título:**  
19. **Telephone, Teléfono:**

**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee. SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY.

**Empleador:** Se requiere que Ud. feche esta forma y que provea copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y el empleado que haya presentado esta petición dentro de un día hábil desde el momento de haber sido recibida la forma del empleado. EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISSION DE RESPONSABILIDAD.

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**Attachment D**

#210 Accident/Injury/Job Related  
Illness Reporting Procedures  

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San Joaquin County  
HUMAN RESOURCES DIVISION  
44 N San Joaquin Street, Ste. 330  
Stockton, California 95202  
Phone: 209-468-3370 - Risk Mgmt

REPORT OF WORK ABILITY

Employee/Patient Name: ____________________________

Today's date: ____________________________

Next appt date: ____________________________

Date of Injury: ____________________________

Injury: ____________________________  
1) left shoulder, right knee, back

EMPLOYEE IS ABLE TO RETURN TO WORK:

☐ Regular duty starting on ____________________________

☐ Modified duty on ____________________________

Restrictions are: ☐ Temporary ☐ Permanent

☐ OFF WORK until ____________________________

TOTAL WORK HOURS PER DAY

☐ No Restriction

☐ 10 - 12 hours ☐ 4 - 6 hours

☐ 2 - 8 hours ☐ 1 - 3 hours

Activity Chart for MODIFIED DUTY below ☑ check ONLY those ACTIVITIES that are RESTRICTED

<table>
<thead>
<tr>
<th>Activity</th>
<th>Unable</th>
<th>Rarely</th>
<th>Occasional</th>
<th>Frequently</th>
<th>Constant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drive @ work</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>Stand</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Walk</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Sit</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Run</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Bend/ Stoop</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Squat</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Climb</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Crawl</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Kneel</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Twist</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Reach</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
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<tr>
<td>Overhead</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Hand: Specify:</td>
<td>☑ Right</td>
<td>☑ Left</td>
<td>☑ Both</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Grasp</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Finger</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Date Entry</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Write</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>File</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

Date: ____________________________

Physician Name - Please print: ____________________________

12/16/2006, Rev

Attachment E

#210 Accident/Injury/Job Related Illness Reporting Procedures  Page 11 of 16
NOTICE OF LEAVE OF ABSENCE FOR TEMPORARY DISABILITY INDEMNITY PAYMENT (FORM 29)

GENERAL INFORMATION

The following steps must have occurred prior to processing your Form 29 request:

1. Report your injury/illness to a Supervisor/Manager.
2. Complete and submit a DWC1-"Employee's Claim for Workers' Compensation Benefits" form.
3. Complete and submit a "Request for Leave of Absence" form.
4. Provide medical documentation for the period of leave and any extensions.

Your department will complete a 5020 "Employers Report of Occupational Injury/Illness" form based on information provided on the DWC1 form. All forms will then be forwarded to the Human Resources, Risk Management Division. Workers' compensation indemnity payments will begin when your claim is approved by San Joaquin County's Third Party Administrator.

Effective 1/1/2005, Employees will have the following options. Please read carefully:
When an employee files a claim for workers' compensation, the Third Party Administrator (TPA) will have a period of time in which to accept, deny or delay a claim. By policy and practice, Workers' Compensation Leave runs concurrently with Family Medical Leave Act (FMLA), which provides 12 weeks of medical leave benefits for an injury/illness for eligible employees. The employee will have the following options to use leave accruals during this "determination period" and following the approval of the claim.

80 hours
Employee may elect to use 80 hours (or regular work schedule) of leave accruals per pay period, which will provide a regular paycheck and continue employee and dependent health insurance coverage. If the worker's compensation claim is approved, employee will receive a partial reimbursement of leave accruals based on the indemnity payment determined by the TPA.

41 hours
Employee may elect to use 41 hours of leave accruals per pay period, which will provide a partial paycheck and continue employee and dependent health insurance coverage. If the workers' compensation claim is approved, employee will receive a partial reimbursement of leave accruals and a partial amount of the indemnity payment determined by the TPA.

0 hours
As a Workers' Compensation applicant, you also have the option of using zero hours. If your workers' compensation claim is denied, this may impact your seniority hours.

Eligible for FMLA
If eligible, health insurance coverage for employee will continue for up to 12 weeks. To continue dependent health insurance coverage, employee should contact Human Resources Benefits Section for employee's portion of premium amount. If the employee elects this option they will be placed on an FMLA-Leave of Absence without pay.

Not Eligible for FMLA
Employee and dependent health insurance coverage will terminate. To continue health insurance coverage, employee should contact Human Resources Benefits Section for information on over-the-counter payment. If the employee elects this option they will be placed on a Medical Leave of Absence without pay.

If the workers' compensation claim is approved, employee will receive a temporary disability indemnity payment for the period and amount determined by the TPA. At that time, employee's health insurance coverage will be reinstated and continuation of dependent health insurance coverage will require an over-the-counter payment to the Human Resources Benefits Section. Employee's leave status will be changed to a Workers' Compensation Leave, which will also adjust seniority hours and leave accruals approved by the TPA.

Retirement Contributions
Contributions towards retirement are based on hours on payroll per pay period. If using less than 80 hours (or regular work schedule) of leave accruals per pay period, contact the San Joaquin County Employee's Retirement Association for information regarding the effect on retirement service credit.

I certify that I have read and understand the above information.

Employee Signature: ___________________________ Date: ____________
Print Employee Name: ___________________________ EE ID#: ____________

Human Resources Form 29 (02/05)
NOTICE OF LEAVE OF ABSENCE FOR
TEMPORARY DISABILITY INDEMNITY PAYMENT

Name: ___________________________ Date: ___________________________
Home Address: __________________ City: ___________________________
Department: ______________________ Division: ______________________
Title: ___________________________ EE ID#: ________________________
Home Telephone: _________________

Our records indicate that you may be eligible to receive Temporary Disability Indemnity payments as a result of an on-the-job injury or illness. The date of your injury or illness was _______________ and you have been off work since _______________. Please read this form and fill in the information requested. Sign and return it to your department with a Request for Leave of Absence form.

WORKERS' COMPENSATION LEAVE

Workers' Compensation leave runs concurrently with Family Medical Leave Act (FMLA). Eligible employees are entitled to 12 weeks of FMLA. After the 12 weeks, if the employee is not released to return to work full duty, workers compensation temporary disability will continue if eligible. Employee must complete a Request for Leave of Absence (RLOA) and Employee's Claim for Workers' Compensation Benefits (DWC1) forms with their department.

WORKERS' COMPENSATION BENEFIT PAYMENT OPTION (See cover page for additional information)

Employee submitting a claim for Workers Compensation Temporary Disability Indemnity payments may elect to use one of the following increments of leave accruals per pay period. The MOU requires sick leave accruals used first. If this is exhausted, employee may elect to use the following:

☐ 80 hours (regular work schedule) ☐ 41 hours ☐ 0 hours (off payroll)
☐ I want to use accrued: ☐ Sick ☐ Vacation ☐ Holiday ☐ Compensatory
☐ I do not want to use any of the above and elect to receive a temporary disability indemnity payment when my claim is approved. (Mark 0 hours, off payroll above).

HEALTH INSURANCE PREMIUMS

The County will continue to pay health and life insurance premiums for employees (but not for dependents) while employees are receiving temporary disability indemnity payments. Employee may continue dependents' health coverage during the time they are receiving temporary disability indemnity payments by paying the premiums in advance to the Human Resources, Benefits Division. Dependents health coverage will continue if you are using 41 hours or more of leave accruals.

RETURN FROM WORKERS' COMPENSATION LEAVE

The employee must present to their department a medical clearance from their physician to return to work.

NOTICE

When Temporary Disability Indemnity payments are discontinued, and all leave accruals have been exhausted, and the employee has not received a medical clearance from their physician to return to work, the employee shall apply for a leave of absence without pay. During leave of absence without pay the employee is responsible for health insurance premium payments. Contact the Human Resources, Benefits Division for more information on continuation of health insurance benefits. While on a leave of absence without pay, employee does not accumulate leave accruals. I certify that I have read the above information.

I certify that I have read the above information. ___________________________ Signature of Employee

FOR DEPARTMENT USE ONLY

Date ___________________________ Appointing Authority or Designated Representative ___________________________

FOR HUMAN RESOURCES USE

Distribution: Original: HR/Risk Management
Copy: Employee's Dept & Timekeeper 
Claim #: ___________________________

Human Resources Form #29 (Revised 10/04)

Attachment F
#210 Accident/Injury/Job Related Illness Reporting Procedures
## COUNTY OF SAN JOAQUIN

### AUTOMOBILE ACCIDENT

Information Reported Herein is Considered Privileged and Confidential

---

### Accident/Injury/Job Related Illness Reporting Procedures

Please Print-Fill Out Immediately | Send One Copy to Public Works-Fleet Services and One Copy to Risk Management | Must be Signed by Supervisor

<table>
<thead>
<tr>
<th>Name of County Driver (Vehicle #1)</th>
<th>Address</th>
<th>Employee ID No.</th>
<th>Age</th>
<th>Driver's License No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department</td>
<td>Division</td>
<td>Location Code No.</td>
<td>County Phone No.</td>
<td></td>
</tr>
<tr>
<td>Date of Accident</td>
<td>Time of Accident</td>
<td>Location of Accident (Intersection or Address)</td>
<td>Law Enforcement Notified?</td>
<td>Yes</td>
</tr>
<tr>
<td>County Vehicle No.</td>
<td>Vehicle License No.</td>
<td>County Vehicle Year</td>
<td>County Vehicle Make</td>
<td>County Vehicle Model</td>
</tr>
<tr>
<td>Describe Damage or Loss/Thief, Specify Property:</td>
<td>Was County Vehicle Towed?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Were you Injured? If yes, Part of Body Affected:</td>
<td>Describe Your Injury</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Driver (Vehicle #2)

<table>
<thead>
<tr>
<th>Name of Other Driver (Vehicle #2)</th>
<th>Driver's License No.</th>
<th>Phone Number</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Registered Owner of Vehicle</td>
<td>Vehicle Insured by</td>
<td>Policy No.</td>
<td></td>
</tr>
<tr>
<td>Registered Owner Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Other Vehicle License No.</td>
<td>Year</td>
<td>Make</td>
<td>Model</td>
</tr>
<tr>
<td>Describe Damage to Other Vehicle</td>
<td>Describe Other Driver's Injury</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

### Injured Person's Name

<table>
<thead>
<tr>
<th>Injured Person's Name</th>
<th>Age</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Describe Injury</td>
<td>Doctor</td>
<td></td>
</tr>
<tr>
<td>Hospitalized</td>
<td>#1</td>
<td>#2</td>
</tr>
<tr>
<td>Pedestrian Hit By</td>
<td>#1</td>
<td>#2</td>
</tr>
<tr>
<td>Passenger Vehicle</td>
<td>#1</td>
<td>#2</td>
</tr>
</tbody>
</table>

### Injured Person's Name

<table>
<thead>
<tr>
<th>Injured Person's Name</th>
<th>Age</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Describe Injury</td>
<td>Doctor</td>
<td></td>
</tr>
<tr>
<td>Hospitalized</td>
<td>#1</td>
<td>#2</td>
</tr>
<tr>
<td>Pedestrian Hit By</td>
<td>#1</td>
<td>#2</td>
</tr>
<tr>
<td>Passenger Vehicle</td>
<td>#1</td>
<td>#2</td>
</tr>
</tbody>
</table>

### Were Any Injured Persons Transported by Ambulance?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Witness Name

<table>
<thead>
<tr>
<th>Witness Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Witness Name</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

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Attachment G

#210 Accident/Injury/Job Related Illness Reporting Procedures

Page 14 of 16
IF YOU WERE DRIVING A PRIVATE VEHICLE ON COUNTY BUSINESS, ANSWER THESE ADDITIONAL QUESTIONS:

Are You Authorized to Drive a Private Car on County Business?  Yes  No

Do You Have Proof of Personal Insurance on File with the County?  Yes  No

Where May Vehicle be Seen (Shop or Address)?  City

Registered Owner of Vehicle (If Other Than Employe)  Phone Number

Address  City  Zip Code

Vehicle Insured By  Policy Number

Conditions:
A. Dry
B. Wet
C. Snow/Icy
D. Slippery (Muddy, Oil, Etc.)

Weather:
A. Clear
B. Cloudy
C. Rainning
D. Snowing
E. Fog
F. Other

ROAD SURFACE:

LIGHTING:

Please show on diagram how accident happened. Give street names.

1. USE THE SYMBOLS BELOW TO COMPLETE THE DIAGRAM
2. GIVE STREET NAME, DIRECTIONS AND LOCATION OF OBJECTS INVOLVED
3. SKETCH IN ANY OTHER SIGNIFICANT OBJECTS OR LANDMARKS
4. PUT NORTH ARROW ON DIAGRAM
5. NUMBER EACH VEHICLE (MAKE YOURS #1) AND SHOW DIRECTION OF TRAVEL BY ARROW

STOP SIGN
SIGNAL
RAILROAD
POINT OF IMPACT
PEDESTRIAN

Indicates points of compass N.E.S.W.

DESCRIPTION OF ACCIDENT
Please Write Legibly. Explain in Your Own Words What Happened. Use Extra Pages if Necessary

I certify that the information in this report is to the best of my knowledge true and correct:

Date  Employee Signature

Supervisor's Name (Please Print)  Supervisor's Signature

S&T 207 Rev 1-07

Attachment G
#210 Accident/Injury/Job Related
Illness Reporting Procedures

Attachment H