ACWA JPIA

WORKERS' COMPENSATION REPORTING KIT

YOUR BEST PROTECTION

WORKERS' COMPENSATION CLAIMS DEPARTMENT

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Workers' Compensation
Claims Reporting Procedures

California law requires every employer to provide workers' compensation coverage for their employees. This coverage ensures benefits for injuries or illnesses that arise out of and in the course of employment. It does not apply to conditions unrelated to work.
If there's uncertainty about whether an injury is work-related, report it to the **JPIA** for review. All questions about claims obligations or procedures should be referred directly to the JPIA.

Your agency is **self-insured**, and workers' compensation benefits are administered by the **JPIA**. Prompt reporting helps ensure coverage and control claim costs.

When to Report a Claim
Report **immediately** to the JPIA when any work-related injury or illness results in:

- Death
- Lost time beyond the date of injury
- Restricted duty
- Medical treatment beyond first aid

Submit claims using one of the following methods:

- **Online**: Using the link on our Website under Report a Claim **https://www.acwajpia.com/report-a-claim/#workerscomp**
- **Email**: **claimswc@acwajpia.com**
- **Fax**: (916) 786-0209

Do not send reports of any kind directly to the Department of Industrial Relations, Workers' Compensation Appeals Board, any attorney, or physician.

Who Should Report
Documentation and reporting of workers' compensation injuries and illnesses is to be handled by the district's workers' compensation claims contact only.

Failure to accurately complete the appropriate forms and report losses timely may result in fines and loss of possible defenses, as well as additional claim costs.

Questions?
Contact ACWA/JPIA Workers' Compensation Department at (800) 231-5742.

WORKERS' COMPENSATION REPORTING KIT

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Please contact ACWA JPIA at (800) 231-5742 for reporting forms or refer to the ACWA/JPIA website at https://www.acwajpia.com/report-a-claim/#workerscomp

WORKERS' COMPENSATION INJURY CHECKLIST

If you have <u>any</u> questions, please call the JPIA's Workers' Compensation Claims Department at (800) 231-5742.

☐ Medical Service Order given to employee unless medical treatment is declined.

☐ Pharmacy First Fill Form given to employee

☐ DWC-1 Form – Workers' Compensation Claim Form & Notice of Potential Eligibility

- ☐ Lines 1, 10, 11, 12, and 13 completed by employer
- ☐ Photocopy taken for file
- ☐ Given or mailed to employee **(must be provided within 1 working day of knowledge of injury)**
- ☐ Employee returned DWC-1 Form **(<u>Only if employee wants to file a claim and treatment is beyond first aid</u>)**
- ☐ Lines 14, 17, 18, & 19 completed by employer
- ☐ DWC1 sent to the JPIA
- ☐ Employee given employee copy
- ☐ Employer copy filed

☐ Form 5020 - Employer's Report of Occupational Injury or Illness
(Must be filed within 5 days of knowledge of injury)

- ☐ Completed and signed by employer
- ☐ Forms should be submitted to the WC Claims email **claimswc@acwajpia.com.**. This is a secure email.
- ☐ Employer's copy filed

☐ Reported to Cal/OSHA
Any serious injury, illness, or fatality must be reported immediately **(but not later than 8-hours)** to the **Cal/OSHA Enforcement District Office** for the area where the incident occurred. The following web link should be referenced.

https://www.dir.ca.gov/dosh/report-accident-or-injury.html

☐ Supervisor's Accident Investigation (to be performed for all work-related injuries and illnesses) **(Do not hold up submitting the 5020 for the completion of the DWC-1 or Supervisor's Accident Investigation Form, however, it is preferred to be submitted as soon as possible)**

- ☐ Investigation complete
- ☐ Preventative actions determined
- ☐ Preventative actions completed
- ☐ Employees informed

Instructions for Completing DWC 1 Form
(Workers' Compensation Claim Form & Notice of Potential Eligibility)

The DWC 1 Form must be provided to the employee within one (1) working day of receiving knowledge of a work-related injury or illness. Knowledge of injury may come from any source. Failure to provide this form to the employee could result in fines and loss of possible defenses. DWC 1 Form is required if treatment is beyond first aid.

The form has both Employee and Employer sections to be completed. Unless otherwise specified, the following are employer instructions. Please type or write legibly.

A. Complete the following lines on the DWC 1 Form:
   1. Employee's Name ***(Do not complete Questions 1-9. This should be completed only by the Employee.)***
   10. Employer's Name
   11. Employer's Address
   12. Date employer first knew of injury
   13. Date claim form provided to employee

B. Make a photocopy of the form for your file.

C. Give employee the DWC 1 Form. If the injured employee is not at work, mail the form to the employee's mailing address.

D. Should the employee wish to file a claim, the employee is to complete lines 2 through 8, complete "Today's Date" on line 1, and provide signature on line 9.

E. Give the employee a photocopy (Temporary Receipt - Carbon copy version of form only).

F. Complete the following lines once completed form is returned to employer:
   14. Date employer received claim form
   17. Signature of employer representative
   18. Title of employer representative
   19. Agency phone number *including area code*

   (Line 15 & 16 is already pre-filled.)

G. Give a photocopy (Employee copy - Carbon copy version of form only) to the employee, or mail to the employee's mailing address.

H. Mail, email, or fax the DWC 1 form (Claims Administrator - Carbon copy version of form only) to the JPIA along with the Form 5020.

I. Retain a photocopy (Employer copy - Carbon copy version of form only) for your files.

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 mailed and when it was delivered. Within one working day 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 previously designated your personal physician or a medical group, you may see your personal physician or the medical group after 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 health care 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 will 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 a doctor outside the HCO 90 or 180 days 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 choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. 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 éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l 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, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted 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 fechada, 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 quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(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 o a 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 hizo 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 su tratamiento es cubierto 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 lo atiende primero a menos de que usted hizo 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. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

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 request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to 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 (Lost 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 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.

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 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, 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

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

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. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar 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 estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

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 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.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

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

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included 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 these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

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

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

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

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete 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 adminstradora de seguros.* _____
ACWA JPIA, PO BOX 619082, ROSEVILLE, CA 95661-9082
16. Insurance Policy Number. *El número de la póliza de Seguro.* **Permissibly Self-Insured**
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 provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

Instructions for Completing Form 5020
(Employer's Report of Occupational Injury or Illness)

The Form 5020 must be filed with the JPIA within five (5) days of knowledge of the injury. **Do not delay** the report because the employee has not yet returned the DWC 1 Form.

This form should be completed by the **employer**. **Do not allow the employee to complete the form**. Please type or write legibly. Fillable form is available on the ACWA JPIA website. **When using the fillable form, years are only two digits (mm/dd/yy).**

All questions should be completed, but please note the following specific questions:

Items 1 through 6 are your agency information.

1A) Insert "Self-Insured"

2A) Agency phone number *including* area code

3A) N/A

4) Insert type of agency (*e.g., Water Utility, Wastewater Utility, Public Utility District, etc.*)

5) Insert agency-specific unemployment number

6) Check "other government" and specify "Special District"

Item 7 through 29 are specifics about the injury or illness.

16) Check the "yes" box **only** if your district has a formal salary continuation program; otherwise check the "no" box if the employee uses his/her accrued benefits.

17) This date must be the same as question 12 on the DWC 1 form

18) This date must be the same as question 13 on the DWC 1 form

26) Describe the nature of the injury in your own words

Items 30 through 39 are employee information.

33a) Employee home phone number *including area code*

35) Employee specific job title

37b) The workers' compensation code under which you report this employee's payroll

This form must be signed and dated by the person completing the document.
(See examples)

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

ACWA/Joint Powers Insurance Authority
PO Box 619082, Roseville CA 95661-9082
(916) 786-5742 (800) 231-5742

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

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

Please do not use this column

CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

ACWA/Joint Powers Insurance Authority
PO Box 619082, Roseville CA 95661-9082
(916) 786-5742 (800) 231-5742

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: Anytown Water District — SAMPLE-NO LOST TIME
1a. Policy Number: Self-Insured
2. MAILING ADDRESS: (Number, Street, City, Zip): P.O. Box 111, Anytown, CA 92345-1111
2a. Phone Number: (916) 786-5742
3. LOCATION if different from Mailing Address (Number, Street, City and Zip): 1234 Main Street, Anytown, CA 92345
3a. Location Code: N/A
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: Water Utility
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☑ Other Gov't, Specify: Special Dist

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 01/07/18
8. TIME INJURY/ILLNESS OCCURRED: 9:00 AM ____ PM
9. TIME EMPLOYEE BEGAN WORK: 7:30 AM ____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☑ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☑ Yes ☐ No
16. SALARY BEING CONTINUED? ☑ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 01/07/18
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 01/07/18
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Deep cut to left arm
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 1234 Main Street, Anytown, CA 92345
20a. COUNTY: Any County
21. ON EMPLOYER'S PREMISES? ☑ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.: Auto repair shop
23. Other Workers injured or ill in this event? ☐ Yes ☑ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold: Screwdriver & wrench
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.: Replacing a water hose on a district vehicle
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: Employee was working under the vehicle hood. While using a screwdriver and wrench to try to pry a bolt loose. Screwdriver slipped and stabbed the employee on the left arm causing a laceration.
27. Name and address of physician (number, street, city, zip): Dr, Joe Smith, 100 Main Street, Anytown, CA 92345
27a. Phone Number: (916) 999-9999
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☑ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Sam Employee
31. SOCIAL SECURITY NUMBER: 111-11-1111
32. DATE OF BIRTH (mm/dd/yy): 07/09/58
33. HOME ADDRESS (Number, Street, City,Zip): 100 Garden Court, Anytown, CA 92345
33a. PHONE NUMBER: (916) 999-9999
34. SEX: ☑ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mechanic
36. DATE OF HIRE (mm/dd/yy): 07/09/90
37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS: ☑ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: 7520
38. GROSS WAGES/SALARY: $ 1500 per week
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☑ No

Completed By (type or print): District supervisor
Signature & Title:
Date (mm/dd/yy):

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

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

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

ACWA/Joint Powers Insurance Authority
PO Box 619082, Roseville CA 95661-9082
(916) 786-5742 (800) 231-5742

OSHA CASE NO.

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EMPLOYER

1. FIRM NAME: Anytown Water District — SAMPLE-LOST TIME & BACK TO WORK
1a. Policy Number: Self-Insured
2. MAILING ADDRESS: (Number, Street, City, Zip): P.O. Box 111, Anytown, CA 92345-1111
2a. Phone Number: (916) 786-5742
3. LOCATION if different from Mailing Address (Number, Street, City and Zip): 1234 Main Street, Anytown, CA 92345
3a. Location Code: N/A
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: Water Utility
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☑ Other Gov't, Specify: Special Dist

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 01/07/18
8. TIME INJURY/ILLNESS OCCURRED: 9:00 AM ____ PM
9. TIME EMPLOYEE BEGAN WORK: 7:30 AM ____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☑ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy): 01/08/18
13. DATE RETURNED TO WORK (mm/dd/yy): 01/20/18
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☑ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☑ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 01/07/18
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 01/07/18
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Deep cut to left arm
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 1234 Main Street, Anytown, CA 92345
20a. COUNTY: Any County
21. ON EMPLOYER'S PREMISES? ☑ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.: Auto repair shop
23. Other Workers injured or ill in this event? ☐ Yes ☑ No
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27a. Phone Number: (916) 999-9999
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☑ No

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Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Sam Employee
31. SOCIAL SECURITY NUMBER: 111-11-1111
32. DATE OF BIRTH (mm/dd/yy): 07/09/58
33. HOME ADDRESS (Number, Street, City,Zip): 100 Garden Court, Anytown, CA 92345
33a. PHONE NUMBER: (916) 999-9999
34. SEX: ☑ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mechanic
36. DATE OF HIRE (mm/dd/yy): 07/09/90
37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS: ☑ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: 7520
38. GROSS WAGES/SALARY: $ 1500 per week
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☑ No

Completed By (type or print): District supervisor
Signature & Title:
Date (mm/dd/yy):

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

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

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

ACWA/Joint Powers Insurance Authority
PO Box 619082, Roseville CA 95661-9082
(916) 786-5742 (800) 231-5742

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: Anytown Water District — SAMPLE-LOST TIME & STILL OFF WORK
1a. Policy Number: Self-Insured
2. MAILING ADDRESS: (Number, Street, City, Zip): P.O. Box 111, Anytown, CA 92345-1111
2a. Phone Number: (916) 786-5742
3. LOCATION if different from Mailing Address (Number, Street, City and Zip): 1234 Main Street, Anytown, CA 92345
3a. Location Code: N/A
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: Water Utility
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☑ Other Gov't, Specify: Special Dist

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 01/07/18
8. TIME INJURY/ILLNESS OCCURRED: 9:00 AM ____ PM
9. TIME EMPLOYEE BEGAN WORK: 7:30 AM ____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☑ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy): 01/08/18
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☑
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☑ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☑ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 01/07/18
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 01/07/18
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Deep cut to left arm
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 1234 Main Street, Anytown, CA 92345
20a. COUNTY: Any County
21. ON EMPLOYER'S PREMISES? ☑ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.: Auto repair shop
23. Other Workers injured or ill in this event? ☐ Yes ☑ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold: Screwdriver & wrench
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.: Replacing a water hose on a district vehicle
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: Employee was working under the vehicle hood. While using a screwdriver and wrench to try to pry a bolt loose. Screwdriver slipped and stabbed the employee on the left arm causing a laceration.
27. Name and address of physician (number, street, city, zip): Dr, Joe Smith, 100 Main Street, Anytown, CA 92345
27a. Phone Number: (916) 999-9999
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☑ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Sam Employee
31. SOCIAL SECURITY NUMBER: 111-11-1111
32. DATE OF BIRTH (mm/dd/yy): 07/09/58
33. HOME ADDRESS (Number, Street, City,Zip): 100 Garden Court, Anytown, CA 92345
33a. PHONE NUMBER: (916) 999-9999
34. SEX: ☑ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mechanic
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38. GROSS WAGES/SALARY: $ 1500 per week
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☑ No

Completed By (type or print): District supervisor
Signature & Title:
Date (mm/dd/yy):

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

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Supervisor's Accident/Incident Investigation Form

Use for Industrial Injuries, Illnesses, or Near Misses

When

Date of incident: Time of incident:	Date reported to supervisor:

Who

Injured employee name: Department:	Job Title: Length of Employment:

Where

Exact location of occurrence:

Loss

Nature and extent of injuries or property damage:

What

Describe specifically what the individual was doing at the time of the incident:

Root Cause(s) (check all that apply)

MATERIALS	ENVIRONMENTAL	PERSONAL
☐ Improper, defective or damaged tool or equipment ☐ Equipment or tool failure ☐ PPE failure ☐ Hazardous product ☐ Hazardous chemical ☐ Improper apparel ☐ Not otherwise classified (Describe):	☐ Inadequate safeguards ☐ Location hazards ☐ Poor housekeeping ☐ Poor storage practices ☐ Toxic or hazardous gases, or fumes ☐ Inadequate lighting ☐ Poor weather conditions ☐ Too hot or too cold ☐ Not otherwise classified (Describe):	☐ Bodily conditions, i.e. health issues, tired, under stress ☐ Pressure to complete task ☐ Poor ergonomics ☐ Lack of skill or knowledge ☐ Adequate skill or knowledge, but failure in execution ☐ Did not receive adequate training ☐ Did not inspect tool or equipment prior to use ☐ Not otherwise classified (Describe):
MANAGEMENT	**TASK**	**OTHER**
☐ No written procedures ☐ Lack adequate supervision ☐ Lack of training provided ☐ Ineffective inspection program or corrective action not taken ☐ Pressure to get job done ☐ Not otherwise classified (Describe):	☐ Safe work procedures not followed ☐ Conditions changed to make the normal procedure unsafe ☐ Appropriate tools not used or not available ☐ Not otherwise classified (Describe):	☐ _____ _____ _____ _____ _____

© ACWA/JPIA
2100 Professional Dr, Roseville, CA 95661

Why

Comment Fully:

Root Cause

Supervisor's Accident Investigation Form (Cont.)

Prevention

What should be done and by whom to prevent recurrence of this type of incident? (Include target dates.)

What immediate actions have been taken? By whom?

What long term actions will be needed? (Include target dates.)
Install railing

Name of Supervisor: _____ Date: _____

Signature: _____

Comments by Dept. Head or Manager

Based on the supervisor's report, write a concise statement commenting on why the injury occurred, and whether the corrective actions (taken and planned) are complete enough to prevent recurrence.

© ACWA/JPIA

Name of Dept. Head or Manager: _____ Date: _____

Signature: _____

© ACWA/JPIA

MEDICAL SERVICE ORDER

Doctor Name: _____

Address: _____

Employee Name: _____ **was injured on**

_____ _____ **while in our employ.**
(Date) **(Time)**

Please render necessary medical treatment immediately, then complete and forward the Doctor's First Report Of Occupational Injury Or Illness to:

ACWA/Joint Powers Insurance Authority
c/o Manageware
PO Box 6510 Mesa, AZ. 85216
(800) 231-5742 FAX (916) 965-6847
Provider Fax # for RFA Intake (602) 536-0905

Employer: _____

Address: _____

Employer Representative: _____ **Date:** _____

One time visit only - call ACWA/JPIA for authorization

MEDICAL SERVICE ORDER

Doctor Name: _____

Address: _____

Employee Name: _____ **was injured on**

_____ _____ **while in our employ.**
(Date) **(Time)**

Please render necessary medical treatment immediately, then complete and forward the Doctor's First Report Of Occupational Injury Or Illness to:

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PO Box 6510 Mesa, AZ. 85216
(800) 231-5742 FAX (916) 965-6847
Provider Fax # for RFA Intake (602) 536-0905

Employer: _____

Address: _____

Employer Representative: _____ **Date:** _____

One time visit only - call ACWA/JPIA for authorization

Occupational Injury/Illness Report

Instructions:
The employee completes this form. Please state facts as accurately as possible. Provide this form to your Supervisor.

Name of Employee	Job Title	
Home Address	Phone Number	
Date and Time of Incident	Date, Time & Supervisor Reported to:	
Location of Incident	City	Building/Room
Describe specifically what you were doing at the time of the incident/accident:		
What body part was injured?		
Name of witness:		
Did this incident cause any property damage? ☐ Yes ☐ No If yes, please describe:		

I _____ accept/decline (circle one) to seek medical treatment at this time. Note: I understand should I require any medical treatment for this incident in the future, I will advise my Supervisor immediately. (Labor Code § 5405 states you have up to 1 year from the date of injury to seek medical treatment)

Employee Print Name

_____ _____

Supervisor signature Date

_____ _____

Employee signature Date

Revised: 7/24/19

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

To the Pharmacist:

myMatrixx, an Express Scripts Company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $750. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: ZWNA

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

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Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

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