SAVE PRINT CLEAR

A copy of this form must be provided to the Employee once completed as a temporary receipt of reporting.

This packet defaults the same text field information throughout the forms.

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

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.

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.

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.

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 arr*** To be Completed by the Supervisor.

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.*** To be Completed by the Supervisor.

10. Name of employer. *Nombre del empleador.* San Mateo County Community College District
11. Address. *Dirección.* 3401 CSM Drive, San Mateo, CA 94402
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.* _____
    Sedgwick Claims Management Services - MCU WC, P.O. Box 14479, Lexington, KY 40512-4479
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 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*

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

Office of Human Resources
3401 CSM Drive – San Mateo, CA 94402
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

Reset Form

Injury/Illness Incident Report

Print Form

Injurer's Name: _____ Date of Injury: _____ ☐ Male ☐ Female

☐ CAÑADA COLLEGE ☐ CHANCELLOR'S OFFICE ☐ COLLEGE OF SAN MATEO ☐ SKYLINE COLLEGE

Category: ☐ Permanent Employee ☐ Adjunct Faculty ☐ Short-Term/ Student Asst ☐ Visitor ☐ Student ☐ Volunteer

Home Address: _____ Date of Birth _____

Home Telephone: _____ Alternative Telephone _____ SS#: _____

Description of Incident: Time of injury/illness: _____ AM/PM Incident Location: _____

What were you doing before the incident occurred?

_____

_____

How did the injury occur (give all factors of contribution to accident/object/substance directly harmed you)?

_____

_____

What was the injury or illness (body part injured and type of injury)? _____

Witnesses Name(s): _____

Health Care:

Student Insurance Information (Student Accident Insurance is secondary):

☐ Advise student to report to health center if medical claim needs to be filed.

Health Center Care Treatment: ☐ College Nurse ☐ First Aid ☐ 911 ☐ Campus Security ☐ Other _____

Care Administered by: _____

Employment/Volunteer Health Care:
Note: Must have Pre-designated Personal Physician in writing before the injury/illness occurred.
If pre-designation did not occur, must refer injurer to District Designated Medical Facility List for medical treatment.

Pre-designated Personal Physician or Facility / Physician Where Treatment Occurred Contact Information:

Name: _____ Address: _____

Were you seen in the emergency room? _____ Were you hospitalized overnight as an in-patient? _____

If no medical treatment is needed, please select the below.

☐ I decline medical treatment at this time. Should I decide to obtain medical treatment in the future, I will notify Human Resources and/or my supervisor. I understand that my failure to do so may cause a delay, as well as possible denial of payment for any treatment.

Employment Information:

Department: _____ Supervisor Name: _____

Job Title: _____ Date of Hire: _____ Time Work Started: _____ AM/PM

Signature of Injurer: _____ **Date:** _____

Health Center Distribution: District Office, Operations, Health Center, Instructor

Please return this form to Human Resources.

This form can be used for any type of incident reporting and awareness.
Rev. Jan 2017

Sedgwick CMS

P.O. Box 14479, Lexington, KY 40512-4479
PHONE: (877) 809-9478 • FAX: (510) 302-3264

Employee Name: _____ SSN: _____
Employer: San Mateo County Community College District

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL INFORMATION:

So that Sedgwick Claims Management Service may process your claim for workers' compensation benefits, please complete and return this form as soon as possible. A return envelope is enclosed.

For purposes of this document the term "Information" shall include all medical records, hospital and outpatient records, reports, charts, notes, histories, laboratory records and reports, diagnostic test reports, doctors' and nurses' notes, correspondence, radiological films, charges, and all other materials concerning, describing or relating to any and all care, treatment, and/or evaluation received by the undersigned.

AUTHORIZATION

To the Parties identified on the attached Medical History Form:

The undersigned hereby authorizes Sedgwick Claims Management Service, and/or its authorized representative or designee, to review, inspect, copy, and/or photograph any and all Information you have concerning, describing or relating to:

1. The evaluation and/or diagnosis of any mental or physical condition for which workers' compensation is now being claimed;
2. Any treatment or therapeutic regimen prescribed or recommended for any mental or physical condition for which workers' compensation is now being claimed;
3. Any and all functional limitations relating to my ability to perform my current job duties;
4. Any modification of my current job duties that is necessitated by the mental or physical condition for which workers' compensation is now being claimed. (Such Information shall include, without limitation, the Doctor's First Report of Injury & Illness (DFR), Verification of Treatment (VOT), work slips, etc.)
5. The medical rationale for any limitation identified in Item 3 above, including specifically and without limitation, a finding that I am unable to work as a result of the mental or physical condition for which workers' compensation is being claimed;
6. Any other physical and/or mental condition, irrespective of whether such condition first occurred before or after the onset of the condition for which workers' compensation is now being claimed, that has affected, may affect or is in any way related to, the onset, nature, scope, duration, prognosis or resolution of the physical or mental condition for which workers' compensation is now being claimed.

The released information is required for the following reason:

To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the nature of causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions that might have medical, legal or factual implications in the injury or injuries as listed on my Employee Claim Form (DWC-1 Form).

A refusal to authorize access to some or all of the requested Information may result in a delay in processing my claim for workers' compensation benefits and/or a denial of my claim.

Release records and information regarding:

Name of Patient (List Other Names Used)	*Medical Record*	*Date of Birth (please verify)*
Address	*Telephone Number*	*Soc Sec # (please verify)*

Release medical information to: Sedgwick Claims Management Service -MCU
Name of Receiving Party, Third Party Workers' Compensation Administrator
P.O. Box 14479, Lexington, KY 40512-4479
Address City State Zip

DURATION: I understand that this authorization shall become effective immediately upon execution and shall remain in effect until one year from the date of my signature.

REVOCATION: I understand that this Authorization may be revoked in writing by the undersigned at any time. Written

revocation will be effective upon receipt, but will not be effective to the extent that Sedgwick Claims Management Service or any disclosing party (medical or healthcare provider) has previously acted in reliance upon this Authorization.

REDISCLOSURE: I expressly authorize Sedgwick Claims Management Service to disclose my Information to any employee, representative, agent, or third person as may be necessary for the proper evaluation and processing of my claim. I understand that the third persons to whom my Information may be given include, without limitation, attorneys, nurse case managers, rehabilitation specialists, physicians and other experts and consultants engaged by Sedgwick Claims Management Service to assist it in the evaluation and management of my claim. Any such disclosure to third persons will be made in confidence and in accordance with the provisions of any applicable law. I also understand that Sedgwick Claims Management Service may disclose my Information in any manner that is required by law (e.g., subpoena, court order, etc.)

SPECIFY RECORDS: Check the box and initial which type of information is to be disclosed.

☐ MEDICAL INFORMATION _____ *Initial*

☐ PSYCHIATRIC INFORMATION

_____ *Signature* _____ *Date*

☐ DRUG/ALCOHOL INFORMATION

_____ *Signature* _____ *Date*

☐ RESULTS OF AN HIV BLOOD TEST

_____ *Signature* _____ *Date*

☐ OTHER HEALTH INFORMATION (specify) _____

A photocopy of this authorization is as valid as the original.

I have read this authorization and fully understand its entire contents. I understand that by signing this form I am authorizing ALL PROVIDERS identified on THE MEDICAL HISTORY FORM to release my Information as provided for above. I have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

_____ *Signature of Patient or Patient's Representative* _____ *Date*

_____ *Indicate Relationship (if Signed by Other Than Patient)* _____ *Date*

Sedgwick CMS

P.O. Box 14479, Lexington, KY 40512-4479
PHONE: (877) 809-9478 • FAX: (510) 302-3264

Date: _____

Employer: San Mateo County Community College District
Employee Name: _____ SSN:_____
Home Address:_____ City: _____
State: CA Zip Code: _____

Medical History Form

To the best of your recollection, please list below ***all*** medical providers (doctors or medical groups, hospitals, chiropractors, acupuncturists, therapists, etc.) you have seen for examination and/or treatment *of both work-related and non-occupational injuries, illnesses and medical conditions at any time in the past.* Your signature on the enclosed Authorization for Use and/or Disclosure of Medical Information will permit Sedgwick Claims Management Service to obtain medical information from every provider identified on this list.

Thank you for your assistance in expediting your claim processing.

Medical Provider Name	*Address*	*Dates Seen*	*Treatment For*

Please use reverse side of form if necessary

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.

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

Please complete in triplicate (type if possible) Mail two copies to:

Sedgwick Claims Management Service
P.O. Box 14479, Lexington, KY 40512-4479

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
San Mateo County Community College District

1a. Policy Number

2. MAILING ADDRESS: (Number, Street, City, Zip)

2a. Phone Number
(650) 574-6555

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.
educational institution

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
San Mateo

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)

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.

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

Office of Human Resources
3401 CSM Drive – San Mateo, CA 94402
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

SUPERVISOR'S INJURY/ILLNESS INVESTIGATION REPORT

☐ CAÑADA COLLEGE ☐ CHANCELLOR'S OFFICE ☐ COLLEGE OF SAN MATEO ☐ SKYLINE COLLEGE

Employee Name:			
Department:		How Long Employed:	
Job Title:		Location of Accident:	
Date Reported:		Date & Time of Accident:	
Was Employee Sent/seen by Dr?	☐ YES ☐ NO	If Yes, where?	
Was First Aid Given?	☐ YES ☐ NO	Was Time Lost?	☐ YES ☐ NO
First Aid Given By Whom?		How Many Days?	

IDENTIFICATION OF THE ACCIDENT FACTORS

Injury and/or Damage:

Brief Description of Accident (What Happened):

Accident Type (check one)	☐ Struck By	☐ Fall	☐ Inhalation	☐ Contact With Electrical Current
	☐ Struck Against	☐ Repetitive Motion	☐ Ingestion	☐ Exposure to Temperature Extremes
	☐ Overextended	☐ Caught In / On / Between	☐ Absorption	☐ Rubbed or Abraded

Any Witnesses? Provide Name(s):

ACCIDENT CAUSES

What Specific Act was Responsible for this Accident?

What Specific Condition was Responsible for this Accident?

REASONS - Why was the Act Committed and/or Why did the Condition Exist? (please specify on the lines below)

☐ Lack of Knowledge/Experience ☐ Attitude ☐ Human Limitation ☐ Condition

CORRECTIVE ACTION

What Do You Suggest be Done to Prevent a Similar Accident?

☐ Instruction / Training ☐ Motivation / Discipline ☐ Proper Equipment Placement ☐ Repair / Eliminate ☐ Recommend to Manager

(Please Specify)

What Actions Have You Taken?

Supervisor Signature	Date	Administrator Signature	Date

PLEASE RETURN TO HUMAN RESOURCES.

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Cañada College • College of San Mateo • Skyline College

MEDICAL TREATMENT AUTHORIZATION FORM

To Be Completed by Employer:

MEDICAL FACILITY: *See designated medical panel clinic listing		**DATE:**	
ADDRESS:			
TELEPHONE:		**FAX:**	

This authorization is issued to you to provide initial medical treatment to the employee named below who has reported an occupational injury.

EMPLOYEE NAME:		**SS #:**	
ADDRESS:			
OCCUPATION:		**DATE OF INJURY:**	
TIME OF INJURY:		**TYPE OF INJURY:**	
WAY INJURY OCCURRED:			

Employer

San Mateo County Community College District
3401 CSM Drive
San Mateo, CA 94402
Tel: (650) 358-6724
Fax: (650) 574-6574
Attn: Ingrid Melgoza,
Senior Human Resources Representative

Workers' Compensation Administrator

Sedgwick Claims Management Services
P. O. Box 14154
Lexington, KY 40512-4479
Tel: (925) 988-1536
Fax: (510) 302-3264
Attn: Linda Rocha,
Claims Examiner

Instructions to Medical Provider:

1. Call the employer contact named above immediately to discuss availability of modified duty if the employee has any injury-related physical restrictions that may affect the employee's ability to return to full duty.
2. Send the completed Doctor's First Report (5021), all medical bills and corresponding reports to Sedgwick Claims Management Service at the address listed above.
3. Contact Sedgwick Claims Management Service immediately if any of the following apply:
   - Questionable Injury
   - Diagnostic Imaging Request
   - Consultation Request
   - Surgery/Hospitalization Request

Contact Sedgwick Claims Management Service Utilization Review (916) 851-8028,
Fax: (916) 851 8076 for authorization requests.

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT WORKERS' COMPENSATION MEDICAL PANEL

DESIGNATED

MEDICAL FACILITIES

Rev. August 2021

Concentra
3 South Linden Avenue
South San Francisco, CA 94080
Tel: (650) 238-1500
Fax: (650) 238-0508
Monday - Friday: 8:00a.m. – 8:00p.m.
Saturday 10:00a.m. - 2:00p.m.

Concentra
125 Shoreway Road Suite A
San Carlos, CA 94070
Tel: (650) 556-9420
Fax: (661) 678-2779
Monday - Friday: 8:00a.m. - 5:00p.m.

24-HOUR EMERGENCY FACILITIES

The facilities listed below are optional 24-hour emergency situations near our colleges that offer 24-hour emergency services. In an emergency situation you should go to the nearest emergency facility.

An emergency situation is one that is LIFE THREATENING or which involves a severed member, permanent disfigurement, or risk of loss of your eyesight.

Seton Medical Center Emergency Dept.
1900 Sullivan Avenue
Daly City, CA 94015
Tel: (650) 692-4000

Peninsula Medical Center Emergency Dept.
1783 El Camino Real
Burlingame, CA 94010
Tel: (650) 696-5400

Mills Health Center Emergency Dept.
100 South San Mateo Drive,
San Mateo, CA 94401
Tel: (650) 696-4500

Sequoia Hospital Emergency Room
170 Alameda de las Pulgas
Redwood City, CA 94062
Tel: (650) 367-5541

SCHOOL MEDICAL PANEL

Labor Code Section 4600 provides that any reasonably required medical treatment necessary to cure or relieve the effects of a work related injury or illness will be provided by the employer at no charge to the employee. For the first thirty (30) days from the date of injury, the employer has the right to select the physician(s) who will provide the mandated medical treatment. If the injured worker is not satisfied with the initial treating physician, he/she may elect to transfer treatment to a physician of his/her choosing after thirty (30) days.

To facilitate and promote compliance with the Labor Code, this Medical Panel is provided to readily identify those physicians and medical facilities which have received specific authorization to treat school district injured workers.

Additionally, any employee has the right to pre-designate a PERSONAL PHYSICIAN by submitting, in writing to the employer prior to any injury in question, the name, address, and phone number of the physician who has treated the employee in the past, possesses the employee's medical history, and some or all of the employee's medical records.

Whoever is selected to provide medical treatment for a work injury must adhere to all provisions of the mandates relating to the reporting of and billing for work injuries and illnesses.

The treating physician, inquiries, request for payment, medical reports, etc., should be directed to:

Sedgwick Claims Management Services

P.O. Box 14154, Lexington, KY 40512-4479

Tel: (866) 554-6477 Fax: (916) 851-8076