Save Document | Reset Form | Print

SAN MATEO COUNTY
COMMUNITY COLLEGE DISTRICT

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

# DISTRICT VOLUNTEER SERVICE INFO / FORMS

☐ Skyline College ☐ College of San Mateo ☐ Cañada College ☐ Chancellor's Offc.

| | | | |
|---|---|---|---|
| **Volunteer Name:** | | Div/Dept: | |
| Div / Dept Supervisor Name: | | Supervisor Tel Num: | |
| Employee Home Address: City, State, Zip | | Home Phone:<br><br>E-mail: | |

## In case of emergency, please notify:

**(Please Complete by Order of Contact / Minimum of Two Emergency Contacts is Preferred.)**

| **#1 Emergency Contact** | | **#2 Emergency Contact** | |
|---|---|---|---|
| **Name:** | | **Name:** | |
| Relationship to Employee: | | Relationship to Employee: | |
| Day/Evening Phone #: | | Day/Evening Phone #: | |
| Home Address: City / State / Zip | | Home Address: City / State / Zip | |

I will volunteer in this division / dept beginning on (date) _____ and ending on (date) _____.

I understand that it is my responsibility to update the information included in this form. I understand that I may submit a claim for District Worker's Compensation benefits should any injury occur while performing this volunteer work.

**VOLUNTEER SIGNATURE:** _____ **DATE:** _____

**DIV / DEPT SUPERVISOR SIGNATURE:** _____ **DATE:** _____

**Please complete the workers' compensation pre-designate personal physician form if you would like to be treated by your personal physician prior to sustaining an injury/illness due to work related injury/illness.**

**Items Included in this Packet:**



Rev. 10/10

SAN MATEO COUNTY
COMMUNITY COLLEGE DISTRICT

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

# VOLUNTEER WORK LOG

**VOLUNTEER NAME:** _____

**DIV. / DEPT. SUPERVISOR NAME** _____

| DATE | START TIME | END TIME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# NEW HIRE WORKERS' COMP PAMPHLET

## WORKER'S COMP COVERAGE

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures such as hurting your wrist from doing the same motion over and over). Generally, independent contractors, and volunteers who receive no compensation are not covered by workers' compensation benefits.

## BENEFITS

Workers' compensation benefits include: Medical care, temporary disability, permanent disability, supplemental job displacement voucher, and death benefits.

## MEDICAL CARE

You are entitled to medical care that is reasonably required to cure or relieve you from the effects of your work-related injury. Medical care may include doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. Providers should never bill you directly for work-related injuries. There is a limit on some medical services. Your employer is required to provide you with a claim form within one (1) business day of learning about your injury. It is extremely important that you complete the "Employee" section of the claim form as your employer is required to authorize medical care within one (1) working day after you file the form. If additional care is necessary after the initial treatment, Sedgwick CMS may authorize care that is appropriate for your injury, including the referral to a specialist.

SMCCCD has designated facilities (see District downloads, worker's compensation folder – http://www.smccd.edu/portal) near the work premises to treat injuries/illnesses that occur out of your employment where medical treatment will be provided.

**YOUR PRIMARY TREATING PHYSICIAN (PTP)** This is the doctor with overall responsibility for treating your injury or illness. The primary treating physician determines what type of treatment you need and when you may return to work. A multispecialty medical group of licensed doctors and osteopathy can be designated as personal physicians. You may request a change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness to Sedgwick CMS. If specialists, diagnostics, etc. are needed in your case, this physician will be responsible for making the referrals. If you name your personal physician before your injury, you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days.

## YOUR PERSONAL PHYSICIAN CARE

You may be treated by your personal physician if you notify your employer prior to your injury. A personal physician includes a medical group of licensed doctors of medicine or osteopathy. Please have your physician complete a pre-designate personal physician form (see District downloads, worker's compensation folder – http://www.smccd.edu/portal) and return it to Human Resources Office. The following requirements must be met:

1. Your employer must offer group health coverage
2. Your personal physician must agree in advance to treat you for any work injuries or illnesses
3. Your physician must be your regular physician and surgeon.
4. Your physician has previously directed your medical treatment and retains your records, including your medical history.

## EMERGENCY MEDICAL CARE

If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department.

## FIRST AID

If you need first aid treatment, contact your college nurse or Human Resources. If you have more than a simple first aid injury, you will need to ask your employer for a claim form.

## REPORT YOUR INJURY

Report the injury immediately to your supervisor or your college business office or Human Resources at (650) 358-6724.

Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for your alleged injury and shall be liable for up to ten thousand dollars ($10,000) in treatment until the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($ 10,000). If your claim is denied, you have the right to appeal the decision within one year of the date of injury.

## MEDICAL PROVIDER NETWORKS

Your employer may be using a MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If your employer is using a MPN, a MPN notice should be posted next to this poster to explain how to use the MPN. If you have pre-designated your personal physician prior to your work injury, then you may receive treatment from your pre-designated doctor. If you have not pre-designated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by the employer. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN.

If your employer has Medical Provider Network additional information can be obtained by reviewing the full employee notification which is required to be posted in close proximity to the workers' compensation poster.

If your employer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist

following a work-related injury or illness within 30 days of reporting your injury. You may use the attached Notice of Personal Chiropractor or Personal Acupuncturist form to notify your employer of this change.

## EMPLOYER DISPUTES YOUR INJURY

State law requires employers to authorize medical care within one working day of receiving a DWC 1 claim form. Your employer may be liable for as much as $10,000 in medical care until your claim is accepted or denied.

## QUESTIONS

If you have questions, see your employer or the claims examiner who handles workers' compensation claims for your employer.

You may consult 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.

## TEMPORARY DISABILITY BENEFITS (TD)

You may be entitled to payments if you lose wages while recovering. Your temporary disability rate is calculated by multiplying your average weekly wage by two thirds. The first 3 days of disability are not payable under California law unless there is hospitalization at the time of injury or the disability exceeds 14 days. If your physician returns you to work on a modified basis, you may be entitled to wage loss. This is generally calculated by multiplying the difference between your average weekly wage and your earnings during modified duties times two thirds. This is subject to the benefit minimums and maximums set by the California Legislature. Temporary disability benefits are payable within 14 days of the date of injury or knowledge of the injury. Subsequent payments are due every 14 days. For injuries occurring on or after 1/1/08, no more than 104 weeks of temporary disability are payable within 5 years from the date of injury. For longer term conditions (hepatitis B &C, amputations, severe burns, HIV, high velocity eye injuries, chemical burns to the eyes, pulmonary fibrosis, and chronic lung disease) no more than 240 weeks within five years from the date of injury are payable. You may be eligible for state disability benefits from the Employment Development Department (EDD) if TD benefits are stopped, delayed, or denied. There are time limits so contact EDD for more information.

## PERMANENT DISABILITY BENEFITS (PD)

You may be entitled to payments if your physician says your injury has limited your ability to work. The permanent disability rate is calculated by multiplying your average weekly wage by two thirds, subject to statutory minimums and maximums. The amount of permanent disability or impairment may depend on your doctor's opinion, as well as your age, occupation type of injury and date of injury. If you have permanent disability or your claims examiner suspects you have permanent disability, a letter will be sent to you explaining your benefits, including the estimate or total value of permanent disability, weekly payment amount, how the benefit was calculated, and all of your related rights under the California Labor Code, including your right to object to the report upon which the determination is being based. Permanent Disability benefits are payable within 14 days of the last payment of temporary disability benefits or after your physician indicates there is permanent disability. The benefit is payable every fourteen days.

## SUPPLEMENTAL JOB DISPLACEMENT BENEFITS

A nontransferable voucher payable to a state approved school if you are injured on or after 1/1/04, the injury results in a permanent disability, you don't return to work within 60 days after TD ends, and your employer does not offer modified or alternative work. Within 30 days after TD benefits end, your claims examiner will send you a letter outlining whether your employer has a modified job or alternate work available for you and an explanation of your potential rights to a supplemental job displacement benefit. If your employer does not return you to work within 60 days and you have permanent disability, you may chose to receive a nontransferable voucher to use at a state accredited school for education-related retraining or skill replacement. If you qualify for the supplemental job displacement benefit, your claims examiner will provide vouchers up to the maximum established by state law: 1. Up to $4000 for permanent disability awards of more than 0 but less than 15 percent 2. Up to $6000 for permanent disability awards between 15 percent and 25 percent 3. Up to $8000 for permanent disability awards between 26 percent and 49 percent 4. Up to $10,000 for permanent disability awards between 50 percent and 99 percent.

## DEATH BENEFITS

Death benefits are paid to dependents of a worker who dies from a work-related injury or illness. The benefit is calculated and paid in the same manner as temporary disability. This benefit is paid at a minimum rate of $224 per week. The death benefit rates are set by state law and the amount depends upon the number of dependents. If dependent minor children are involved, death benefits are payable at least until the youngest child reaches majority age. Burial expenses are also provided under this benefit.

## CLAIMS ADMINISTRATOR

**Sedgwick Claims Management Services, Inc.**

P.O. Box 2065, Oakland, CA 94604

Telephone: (800) 225-2998

You may contact an information and assistance officer at the State Division of Workers' Compensation, toll free (800) 736-7401, visit http://www.dir.ca.gov, San Francisco Office (415) 703-5020 San Jose Office (408) 277-1292.

## DISCRIMINATION

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

## FALSE CLAIMS AND FALSE DENIALS

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 and may be fined and imprisoned. (Insurance Code 1871.4) Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any off-duty recreational, social, or athletic activity that is not part of your work-related duties.

# San Mateo County Community College District

## workers' compensation: Pre-Designation of Personal Physician

If your employer offers group health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O) if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 to qualify as the your predesignated, personal physician, the physician must agree, in writing, to treat you for a work related injury, must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer in writing prior to being injured on the job and provide written verification that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated worker's compensation medical providers.

**VOLUNTEER NAME**: _____

☐ I acknowledge receipt of this form and elect not to predesignate my personal physician at this time. I understand that I will receive medical treatment from my employer's medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Volunteer Signature: _____ Date: _____

☐ If I am injured on the job, I wish to be treated by my personal physician*:

Name of Physician _____ Phone Number _____

Physician Address _____

*This physician is my personal physician who has previously directed my medical care and retains my medical history and records.

Volunteer Signature: _____ Date: _____

A *Personal Physician* must be willing to be predesignated and treat you for a worker's compensation injury.
*The remainder of this form is to be completed by your physician and returned to your Employer.*

## PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other written documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN NAME: _____

☐ *I agree to treat* the above named employee in the event of an industrial accident or injury. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

☐ *I do not agree* to treat the above employee in the event of an industrial accident or injury.

☐ *I do not qualify* as the employees' personal physician. I am not an M.D. or D.O. or do not meet the criteria outlined above.

_____ _____
Physician Signature Date

Please return completed form to:

Human Resources, SMCCCD, 3401 CSM Dr., San Mateo, CA 94402 Fax: (650) 574-6574