The City of SAN DIEGO

SAN DIEGO FIRE-RESCUE DEPARTMENT

INJURY REPORT ENVELOPE

IT IS THE EMPLOYEE'S RESPONSIBILITY TO MAKE SURE
THE FORMS ARE COMPLETED ACCURATELY.

IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE,
PLEASE CALL MEDICAL DESK AT (619) 533-4360.

SEAL COMPLETED FORMS IN THIS ENVELOPE AND SEND TO
MEDICAL DESK AT MS-604.

FD-9 (Rev. 3-19) PW/PS-2

CALL-IN CENTER INFORMATION

City Supervisors will be asked the following questions when an injury or illness occurs and they report it to the CALL-IN CENTER
1-800-427-7980

1. EMPLOYEE SOCIAL SECURITY NUMBER
2. EMPLOYEE NAME
3. DATE OF INJURY
4. TIME OF INJURY
5. DATE EMPLOYER NOTIFIED OF INJURY
6. TIME EMPLOYEE START WORK (Day of Injury)
7. WHAT IS THE NATURE OF THE INJURY (Sprain, Cut, Burn)
8. WHAT PART OF THE BODY WAS INJURED (Knee, Leg, Arm)
9. WHAT IS THE TYPE OF INJURY (Lifting, Fall, Exposure)
10. WHAT IS THE SOURCE OF THE INJURY (Ladder, Vehicle, Tool)
11. HOW DID THE INJURY OCCUR (Employee fell from ladder)
12. FATALITY
13. DATE OF DEATH
14. DATE CLAIM FORM WAS PROVIDED TO EMPLOYEE
15. DID INJURY HAPPEN ON EMPLOYER'S PREMISES
16. OTHER WORKERS INJURED IN THIS EVENT
17. VOLUNTEER WORKER
18. NAME OF SUPERVISOR REPORTING INJURY
19. PHONE NUMBER OF SUPERVISOR REPORTING INJURY
20. DATE INJURY REPORTED
21. ADDRESS WHERE INCIDENT OCCURRED
22. ADDITIONAL COMMENTS

****Please keep this information handy for future reference****

SAN DIEGO FIRE-RESCUE DEPARTMENT
INJURY REPORT ENVELOPE

FOR OCCUPATIONAL INJURY OR ILLNESS REQUIRING TREATMENT
COMPLETE THE ENCLOSED FORMS
FOLLOWING THE INSTRUCTIONS BELOW

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS FORM: RM-1642

- ☐ Employee completes lines 1 – 8
- ☐ Supervisor completes lines 9 – 18 *(#14: Self-Insured, #15: 944-02856)*
- ☐ Supervisor reports injury to Call-In Center **(800) 427-7980,** within 24 hours of notification of the injury
- ☐ Supervisor writes confirmation number in the top margin of the form once call is completed
- ☐ Supervisor returns Employee's Temporary Receipt (*pink copy*) to employee
- ☐ Supervisor scan/email the form to Addy Zertuche at azertuche@sandiego.gov within 24 hours of notification

SUPERVISOR'S ACCIDENT AND INJURY INVESTIGATION REPORT

- ☐ Supervisor meets with employee to investigate incident
- ☐ Supervisor completes Accident and Injury Investigation Report. Then inter-office mail to MS-604.

MEDICAL STATUS REPORT FOR OCCUPATIONAL INJURY OR ILLNESS FORM: RM-1634

- ☐ Employee completes top portion of the form and brings to medical facility for each visit
- ☐ The City's authorized providers for medical treatment are SHARP Rees-Stealy or Concentra. Locations for these facilities are included in this packet.
- ☐ An employee may immediately seek treatment from their own physician if a **Notification of Election of Personal Physician** form has been completed and is on file with the City's Risk Management Department at least thirty days prior to the injury.
- ☐ Employee has medical facility time stamp the arrival and departure time on the form
- ☐ Physician or Physical therapist completes medical portion of form. For physical therapy appointments only, you can note up to three visits prior to submitting the form to Medical Desk.
- ☐ Employee immediately notifies supervisor and Medical Desk if there is a change in work status and Scan/emails a copy to Medical Desk Representative, Addy Zertuche at azertuche@sandiego.gov
- ☐ Employee forwards ORIGINAL forms to Medical Desk at MS-604 upon completion of medical appointment. Please keep the pink copy for your records.

CITY OF SAN DIEGO
FIRE-RESCUE DEPARTMENT
Supervisor's Accident and Injury Investigation Report

Supervisors are required to investigate all employee injuries and illnesses as soon as they occur. This form provides guidance for completing a thorough and confidential investigation. Investigation reports need to be maintained in Department medical file for the injured employee for a minimum of five years from the date of the injury or illness.

CAL-OSHA REPORTING REQUIREMENTS

Injuries or illnesses resulting in medical treatment beyond first aid must be reported to the Claim Reporting Call-In-Center at (800) 427-7980 within twenty-four (24) hours, however the injury should be reported as soon as possible.

The injury or illness must be reported to Cal/OSHA no later than eight (8) hours after the injury was identified if:

- The injury or illness resulted in death;
- The injury or illness results in inpatient hospitalization for a period in excess of twenty- four (24) hours for anything other than medical observation (employee was admitted for treatment);
- The employee suffered the loss of any member of the body (amputation including loss of tip of finger, nose, ear, etc.)
- Serious permanent physical disfigurement (i.e. severe burns, crushing injury)

Battalion Chiefs (Operations) or the first line supervisor (straight day personnel) must contact Cal/OSHA at (800) 321-6742 or (619) 767-2280 and report the injury as soon as possible.

1: EMPLOYEE INFORMATION – TO BE COMPLETED BY SUPERVISOR

Employee's Full Name:		Male ☐ Female ☐	Station/Division:
Supervisor's Full Name:		Supervisor Phone:	

Division		Classification	
☐ Academy	☐ Fire Prevention	☐ Fire Recruit	☐ Chief Officer
☐ Administration	☐ Lifeguards	☐ Firefighter ☐ I ☐ II ☐ III	☐ Dispatcher / Supervisor
☐ EMS	☐ Logistics	☐ Fire Engineer	☐ Lifeguard Personnel
☐ FCC	☐ Supression	☐ Fire Captain	☐ Other: _____

2: EMPLOYEE INFORMATION – *HUMAN RESOURCES STAFF COMPLETES THIS SECTION ONLY*

Employee Phone:		Date of Birth:	
Employee ID Number:		Date Hired:	

3: INJURY AND ILLNESS INFORMATION – TO BE COMPLETED BY SUPERVISOR

Accident Site: _____

Date of Accident: _____ Accident Time: _____ AM ☐ / PM ☐

Report Confirmation Number *from Claim Reporting Call-In-Center*: _____ Shift Beginning Time: _____ AM ☐ / PM ☐

Number of consecutive hours worked prior to injury/illness: _____

Employee Name: _____ Injury Date: _____

4: Injury Information

Duty Type

☐ **Responding To or Returning From Incidents** ☐ **At the Fire Ground** ☐ **At Non-Fire Emergencies** ☐ **Training** ☐ **Other On-Duty:** Provide description here: ⟹	***Examples of "Other On-Duty" include, but not limited to:*** Beach or Tower duty,Station Routine, Code 9, Water Rescue, etc. Please list below: _____

Nature of Injury

☐ Amputation	☐ Fall, Other	☐ Puncture
☐ Bodily Reaction	☐ Hearing Loss	☐ Respiratory Distress
☐ Bruise/Contusion	☐ Heart Attack/Stroke	☐ Scratch/Abrasion
☐ Burn/Blister	☐ Hernia	☐ Sting/Bite
☐ Cut/Laceration	☐ Hypertension	☐ Strain/Sprain/Muscle Strain
☐ Dermatitis/Skin	☐ Inhalation (Smoke/Gas)	☐ Thermal Stress (Heat Exhaustion)
☐ Dislocation/Fracture	☐ Particle in Eye	☐ Other: _____
☐ Exposure (***Complete Section Below***)		

*Exposures ** Complete Only if Checked Above ***

Hazardous Condition Exposure:	**Infectious/Contagious Disease:**
☐ Asbestos	☐ Flu
☐ Chemical	☐ Hepatitis ⟹ ☐ **A** ☐ **B** ☐ **New**
☐ Fumes	☐ HIV/AIDS/ARC
☐ Radioactive Material	☐ Meningitis
☐ Other: _____	☐ MRSA
	☐ Tuberculosis
	☐ Other: _____

Part of Body

☐ Ankle	☐ Full Body	☐ Multiple Injuries
☐ Arm	☐ Groin	☐ Neck
☐ Back	☐ Hand	☐ Shoulder
☐ Ear	☐ Head	☐ Skin
☐ Elbow	☐ Heart	☐ Throat
☐ Eye	☐ Internal, Other	☐ Toe
☐ Face	☐ Knee	☐ Trunk
☐ Finger	☐ Leg	☐ Wrist
☐ Foot	☐ Lungs	☐ Other: _____
☐	☐ Mouth/Teeth	

Source of Injury

☐ Animal/Insect	☐ Food Product	☐ Physical Agility Exam
☐ Body Position	☐ Furniture	☐ Plants/Vegetation
☐ Building/Structure	☐ Glass	☐ Rescue Equipment
☐ Carrying/Lifing	☐ Ground/Street	☐ Rock
☐ Caught In/Between	☐ Gurney / Backboard	☐ Sand
☐ Chemical (Gas/Liquid/Vapor)	☐ Heat/Fire/Smoke	☐ Siren
☐ Climbing/Jumping/Landing	☐ Hole	☐ Stairs/Steps
☐ Developed Over Time	☐ Hose	☐ Struck by
☐ Citzen	☐ Ladder	☐ Tool (Type: _____)
☐ Containers/Boxes	☐ Machinery	☐ Vehicle
☐ Dust	☐ No Specific Source	☐ Water
☐ Electrical	☐ Ocean/Wave	☐ Watercraft/Equipment
☐ Fall/Slip/Tripping	☐ Other Employee	☐ Workout/Exercise Equipment
☐ Fire Debris	☐ Over Exertion	☐ Other: _____
☐ Floor/Work Surface		

Employee Name: _____ Injury Date: _____

What was the employee doing just before the accident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. (Examples: climbing a ladder while carrying roofing materials; daily computer key entry)

What happened? Tell how the injury occurred. (Example: When ladder slipped on wet floor, the employee fell 20 feet; employee developed soreness in wrist over time.)

5: HEALTHCARE INFORMATION

Yes	No		
☐	☐	Was the employee treated by a physician or other healthcare professional? If yes, name of healthcare professional: _____	Phone number: _____
☐	☐	Was there any treatment provided at the worksite? If yes, who provided the treatment? _____	Phone number: _____
☐	☐	Was the employee treated in an emergency room/urgent care? If yes, name of facility: _____	Phone number: _____
☐	☐	Was the employee hospitalized in excess of twenty- four (24) hours as an in-patient other than for observation? If yes, name of facility: _____	Phone number: _____
☐	☐	Did the employee die? _____	If yes, date of death: _____

Employee Name: _____ Injury Date: _____

6: CORRECTIVE ACTION PLAN AND RECOMMENDATIONS

Describe what steps should be taken to prevent this type of injury and illness from reoccurring. (Example: Recommendation to provide training to all affected employees with regard to proper ladder placement, such as ladders not being placed on uneven or wet ground or any areas where there is a likelihood the ladder may slip.) **Corrective measures should be implemented when possible within 24 hours of the accident.**

Supervisor's recommendations:

Supervisor's Signature:

7: FOLLOW-UP

Describe current situation or explain why no follow up was needed:

Date corrective action taken: **Safety Rep Signature :** _____

Additional follow-up needed?	**Yes ☐ No ☐ Date to revisit:**
Describe the updated situation and what steps were taken to resolve the cause of the injury/illness:	
Date corrective action taken:	**Safety Rep Signature :** _____

A copy of this report may be filed in the injured employee's confidential medical file, managed by the Medical Desk.

The contents of this report may be shared with the City's Risk Management Department to ensure care/treatment is provided to the injured employee under the City's Workers' Compensation policy.

The City of SAN DIEGO

Medical Provider Network (MPN)

For Work Related Injuries

SHARP

NORTH COUNTY
1N RANCHO BERNARDO
858-521-2350
16899 W. BERNARDO DRIVE
OCCUPATIONAL HEALTH SERVICES
MON - FRI : 8 A.M. - 5 P.M.
URGENT CARE SERVICES
DAILY : 8 A.M. - 8 P.M.

CENTRAL COUNTY
1C SORRENTO MESA
858-526-6150
10243 GENETIC CENTER DRIVE
OCCUPATIONAL HEALTH SERVICES
MON - FRI : 8 A.M. - 5 P.M.
URGENT CARE SERVICES
DAILY : 8 A.M. - 8 P.M.

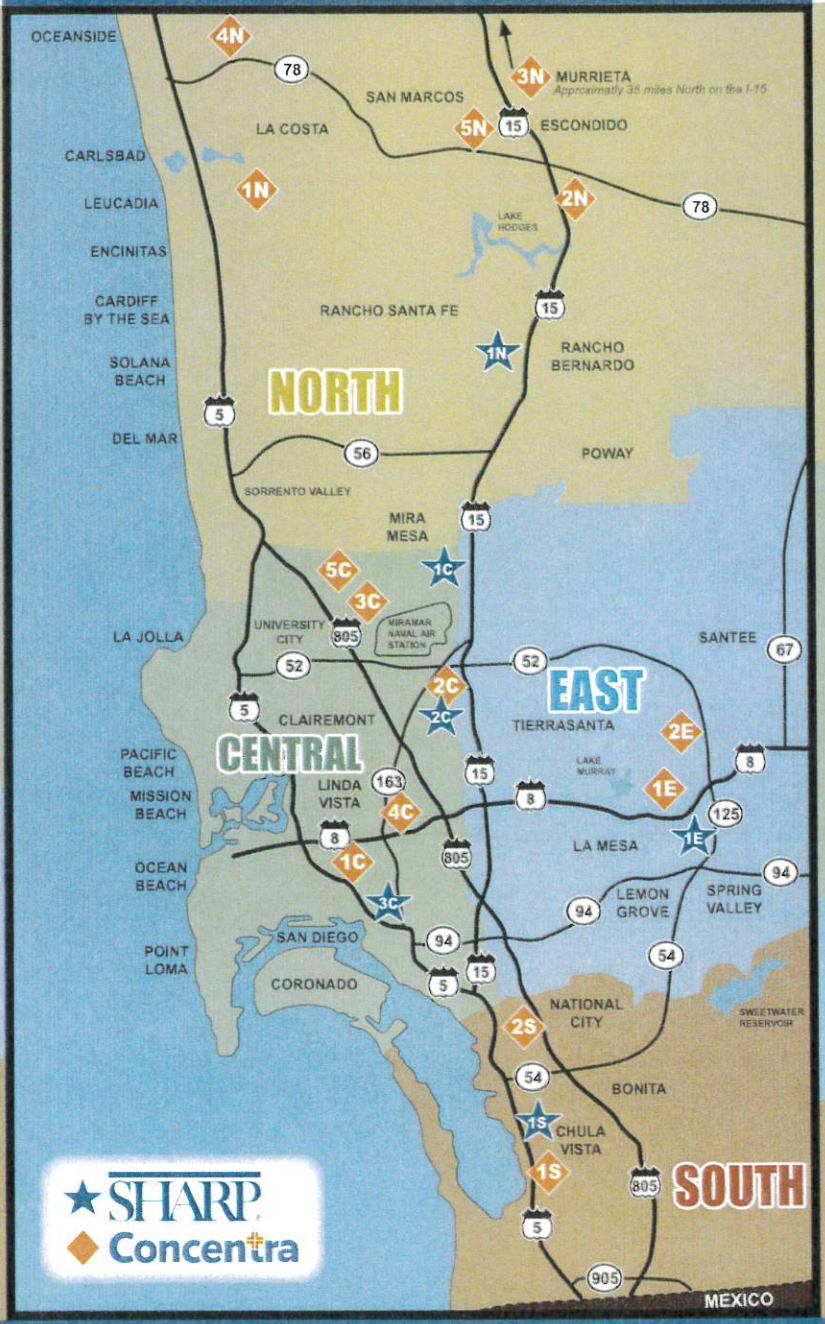
2C KEARNY MESA
858-616-8400
2020 GENESEE
OCCUPATIONAL HEALTH SERVICES
MON - FRI : 7 A.M. - 5 P.M.

3C DOWNTOWN
619-446-1524
300 FIR STREET
OCCUPATIONAL HEALTH SERVICES
MON - FRI : 8 A.M. - 5 P.M.
URGENT CARE SERVICES
WEEKDAYS : 8 A.M. - 10 P.M.
WEEKENDS AND HOLIDAYS
8 A.M. - 8 P.M.

EAST COUNTY
1E LA MESA
619-644-6600
5525 GROSSMONT CENTER DRIVE
SUITE 601
OCCUPATIONAL HEALTH SERVICES
MON - FRI : 8 A.M. - 5 P.M.
URGENT CARE SERVICES
DAILY : 8 A.M. - 8 P.M.

SOUTH COUNTY
1S CHULA VISTA
619-585-4050
525 THIRD AVENUE
OCCUPATIONAL HEALTH SERVICES
MON - FRI : 7 A.M. - 5 P.M.
URGENT CARE SERVICES
DAILY : 8 A.M. - 8 P.M.

OCCUPATIONAL MEDICAL CLINICS



SHARP Concentra

Concentra

NORTH COUNTY
CARLSBAD 1N
760.929.8769
5810 EL CAMINO REAL, STE A
MON - FRI : 7 A.M. - 6 P.M.

ESCONDIDO 2N
760.740.0707
860 W VALLEY PKWY, STE 150
MON - FRI : 7 A.M. - 7 P.M.

MURRIETA 3N
951-600-9070
25115 MADISON AVE
MON - FRI : 8 A.M. - 7 P.M.

OCEANSIDE 4N
760-941-2000
3910 VISTA WAY - SUITE 106
MON - FRI : 7 A.M. - 7 P.M.
SAT : 9 A.M. - 3 P.M.

SAN MARCOS 5N
760-432-9000
740 NORDAHL RD, STE 131
MON-FRI: 8 AM - 8 PM
SAT-SUN: 8 AM - 5 PM

CENTRAL COUNTY
HILLCREST 1C
619.297.9610
3930 FOURTH AVE, STE 200
MON-FRI: 7 AM - 7 PM

KEARNY MESA 2C
858-277-2144
5575 RUFFIN RD STE 100
OPEN 24/7

MIRAMAR 3C
858-549-4255
7590 MIRAMAR RD, STE C
MON - FRI : 8 A.M. - 5 P.M.

MISSION VALLEY 4C
619-295-3355
5333 MISSION CENTER RD, STE 100
MON - FRI : 8 A.M. - 6 P.M.

SORRENTO MESA 5C
858-455-0200
10350 BARNES CANYON RD, STE 200
MON - FRI : 8 A.M. - 5 P.M.

EAST COUNTY
LA MESA 1E
619.697.3093
8090 PARKWAY DR
MON-FRI: 8 AM - 5 PM

SANTEE 2E
619-448-4841
9745 PROSPECT AVE, STE 100
MON-FRI: 7 AM - 5 PM

SOUTH COUNTY
CHULA VISTA 1S
619-425-8212
542 BROADWAY, STE G
MON-FRI: 8 AM - 6 PM
SAT: 9 AM - 3 PM

NATIONAL CITY 2S
619-474-9211
102 MILES OF CARS WAY
MON-FRI: 7 AM - 7 PM

Report injuries immediately to your supervisor.

The Complete list of MPN Physicians and locations can be viewed at
www.sandiego.gov/riskmanagement

This information is available in alternative formats upon request. Revised 11/2018

SWORN EMPLOYEES

REPORTING TO MODIFIED DUTY WORK STATUS

The following applies to sworn employees who have been placed on a modified duty status by a physician.

During business hours (Monday-Friday, 8am – 4:30pm)

1) Notify your first line supervisor of your change in work status
2) Immediately notify the Medical desk (***within 24hrs***) at (619) 533-4360 and inform staff of your work status change. Scan and email a clear copy of your medical status report to Addy Zertuché, Medical Desk Representative at azertuche@sandiego.gov

   Employees have the option to use their own Annual Leave during the Modified Duty timeframe or report to a Modified Duty assignment.

   For those employees requesting a modified duty assignment, once the Medical Desk Representative receives your RM-1634 noting your work restrictions, this information will be forwarded to the Assistant Chiefs for review and they will determine your light duty assignment within the San Diego Fire-Rescue Department.

3) Check your department email for modified duty assignment instructions. If you do not receive an email or phone call, please report to SDFD Headquarters immediately in Class B uniform, for further instructions.
4) The Medical Desk Representative will generate an email of your work status change to modified duty and forward it to Staffing Desk, SDFD Payroll and Risk Management. It is the employee's responsibility to confirm their *Telestaff* Calendar has been properly updated.
5) Contact your payroll specialist via phone/email for proper light duty codes to enter into *OneSD*.
6) A Medical Status Report (RM-1634) is required after each doctor's visit and must be forward to the Medical Desk Representative (email/hand delivered) immediately, so that the department is kept updated on your current work status and work restriction updates.

During weekends/after hours

You will be required to follow the same instructions above; in addition to the following:

- Immediately notify Battalion 1/Staffing Desk- Inform them of your change in work status to modified duty status.
- If you elect to report for a modified duty assignment, please report to SDFD HQ/Human Resources the next business day or Monday at 07:30 in your Class B uniform for further instructions.

CIVILIAN EMPLOYEES

REPORTING TO MODIFIED DUTY WORK STATUS

The following applies to civilian employees who have been placed on a modified work status (*Light Duty*) by a physician.

During business hours (Monday-Friday, 8am – 4:30pm)

- Notify your supervisor of your change in work status

  Immediately notify the Medical Desk (***within 24hrs***) at (619) 533-4360 and inform staff of your work status change. Scan and email a clear photo of your medical status report to Addy Zertuché, Medical Desk Representative at azertuche@sandiego.gov

  Employee may elect to use their own Annual Leave during the modified duty work status timeframe.

  Civilian employees will remain on modified duty within their Division (*if applicable*) and your supervisor will be informed of your work restrictions.

- The Medical Desk Representative will generate an email of your work status change to modified duty and forward it to SDFD Payroll.
- Contact your payroll specialist via phone/email for proper light duty codes to enter into *OneSD*.
- A Medical Status Report (RM-1634) is required after each doctor's visit and must be forward to Medical Desk Representative (email/hand delivered) immediately, so that the department is kept updated on your current work status or work restriction updates.

SWORN EMPLOYEES

PROCEDURE TO RETURN TO FULL DUTY

PLEASE FOLLOW THE STEPS BELOW TO EXPEDITE YOUR RETURN TO FULL DUTY

- A Medical Status Report for Occupational Injury or Illness (RM-1634) must be completed by your physician, indicating the date you are cleared to return to full duty.
- Notify the Medical Desk by calling the Medical Desk Representative (619) 533-4360.
- Scan and email your medical form to azertuche@sandiego.gov .
- Retain the pink copy of the form, RM-1634 for your records and forward the white and yellow copies through interoffice mail to Medical Desk, MS-604.
- Notify your first line supervisor of your change in work status.
- The Medical Desk Representative will notify the Staffing Desk of your change in work status. **It is <u>your</u> responsibility to check and confirm your work status utilizing the Telestaff system.**
- If you have not received confirmation of your change in work status, you may follow up with a phone call to the staffing desk at (619) 692-4951.
- Call the Medical Desk Representative at (619) 533-4360 if you have any questions.

NOTE:

EMPLOYEES WHO HAVE BEEN ON LIGHT DUTY OR INDUSTRIAL LEAVE FOR MORE THAN <u>60 CALENDAR DAYS</u> MUST:

Complete a "**RETURN TO OPERATIONS CHECKLIST**" prior to returning to full duty. This form and further instructions are available by the Medical Desk Representative. Included in the checklist is the **Physical Abilities Test ("killer drill")**. Please contact Training Division IST Coordinator at (619) 692-4984 to schedule this test the **day of or after** your medical release date.

The completed checklist is to be forwarded to Addy Zertuche, Medical Desk Representative via email azertuche@sandiego.gov.
Addy Zertuche will then send out your return to work staffing memo to Telestaff and Payroll.

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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 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.* _____
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 <u>one working day</u> 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* ***<u>un día hábil</u>*** *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*

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 an 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.

{Affix Label Here}

INSTRUCTIONS: *Employee must submit this form to Physician for completion at* ***each*** *Medical Evaluation.*

City of San Diego
Medical Status Report for Occupational Injury or Illness

EMPLOYEE

PRINT NAME (LAST, FIRST, MI)	JOB CLASSIFICATION	SOCIAL SECURITY # (LAST 4)	PERN #

DEPARTMENT / DIVISION	DATE OF INJURY	REOCCURRENCE OF OLD DISABILITY? ☐YES ☐NO	IMMEDIATE SUPERVISOR

BRIEF DESCRIPTION OF OCCUPATIONAL INJURY OR ILLNESS / EXPOSURE:

THE FOLLOWING IS AN UPDATE OF MY MEDICAL STATUS IN REGARD TO INDUSTRIAL LEAVE*, AND/OR LIGHT DUTY. TO PRESERVE MY BENEFITS UNDER THE APPROPRIATE PROGRAM, I WILL SUBMIT A MEDICAL STATUS REPORT **EACH TIME** I RECEIVE AUTHORIZED MEDICAL TREATMENT.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION REQUESTED BY MY EMPLOYER.

X _____ _____ _____

Employee Signature | Date | Phone Number

**INDUSTRIAL LEAVE IS SUBJECT TO APPROVAL BY RISK MANAGEMENT IN ACCORDANCE WITH A.R. 63.00.*

PHYSICIAN

TREATING PHYSICIAN (PRINT NAME)	ADDRESS	PHONE

MARK ALL PRESCRIBED	DATE OF VISIT	TIME IN	TIME OUT	DID INJURY RESULT IN AGG. OF PRE-EXIST. NON-IND. CONDITION?	WORK RELATED INJURY?	
☐ Acupuncture ☐ Medications ☐ Chiropractor ☐ Physical Therapy				☐YES ☐NO	☐YES ☐NO	☐ INITIAL VISIT ☐ RECHECK ☐ FINAL VISIT

☐ RETURN TO REGULAR WORK – EFFECTIVE DATE: _____

☐ RETURN TO WORK WITH FOLLOWING RESTRICTIONS:

- ☐ NO DRIVING OF ANY/COMMERCIAL VEHICLES
- ☐ NO WORKING NEAR MOVING MACHINERY
- ☐ NO PROLONGED SITTING
- ☐ NO PROLONGED STANDING AND WALKING
- ☐ ELEVATE INJURED EXTREMITY TO DECREASE SWELLING
- ☐ SITTING WORK ONLY
- ☐ NO KNEELING OR SQUATTING
- ☐ NO REPETITIVE CLIMBING, BENDING OR TWISTING
- ☐ WEIGHT LIFTING RESTRICTIONS _____ LBS.
- ☐ SEDENTARY WORK ONLY
- ☐ LIMITED USE OF RIGHT/LEFT HAND/UPPER EXTREMITY
- ☐ LIMITED PUSHING/PULLING/GRASPING OF RIGHT/LEFT HAND
- ☐ REPETITIVE HAND/WRIST WORK LIMITED TO _____
- ☐ KEYBOARD WORK LIMITED TO _____
- ☐ CAN WORK IN SPLINT/SUPPORT ONLY/AS NEEDED
- ☐ HAND/NECK/BACK STRETCHING BREAKS FOR _____
- ☐ ROTATE JOB TASKS TO MINIMIZE CONTINUOUS REPETITIVE HAND/WRIST MOTION
- ☐ NO OVERHEAD LIFTING OR REACHING WITH RIGHT/LEFT UPPER EXTREMITY
- ☐ NO OVERHEAD WORK
- ☐ AVOID PROLONGED NECK FLEXED/EXTENDED POSTURE
- ☐ OTHER: _____

☐ UNABLE TO PERFORM ANY WORK ACTIVITIES AT THIS TIME. ESTIMATED DURATION: _____

PHYSICIAN SIGNATURE _____ NEXT APPT. DATE _____

PHYSICAL THERAPY

DATE _____ TIME IN _____ TIME OUT _____ DATE _____ TIME IN _____ TIME OUT _____ DATE _____ TIME IN _____ TIME OUT _____

PAYROLL

INCLUDE DATES OF ABSENCE: FIRST DATE _____ LAST DATE _____ # OF HOURS ABSENT _____

DEPARTMENT

LIGHT DUTY: ☐ IS ☐ IS NOT AVAILABLE AT THIS TIME

_____ / _____ RECOMMEND: ☐APPROVED ☐DISAPPROVED ☐PENDING

Division Head or Designee or Light Duty Coordinator-Print Name / Signature